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ABSTRACT

The Veterans Administration (VA) established the Readjustment Counseling Program in 1980 to assist Vietnam era veterans who had not made a successful psychosocial adjustment to civilian life. The program was intended to make services available at vet centers for veterans reluctant to seek counseling from regular VA health care facilities. At the request of Senator Frank Murkowski, the General Accounting Office (GAO) reviewed specific aspects of the Readjustment Counseling Program to: (1) evaluate the need for retaining vet centers in community-based settings; (2) provide information on characteristics and problems of clients, services provided, staffing, and vet center relations with other agencies and the community; and (3) assess program management, oversight, and recordkeeping. Based on findings of the study, the GAO recommended that the VA should be able to decide on a case-by-case basis whether vet centers should be relocated to existing VA facilities. Clients were found to have motivational or behavioral problems. Centers were found to offer individual and group counseling and employment and VA benefits assistance. The centers had established extensive community networks for outreach and referrals. Most staff members had relevant academic, military, and professional experience. Improved monitoring of centers' activities was considered necessary to help ensure the provision of quality care. (Findings are discussed in detail, 10 tables and 19 figures are included, and relevant materials are appended.) (NB)

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United States General Accounting Office

GAO

Report to the Ranking Minority Member,
Committee on Veterans' Affairs, U.S.
Senate

August 1987

VIETNAM VETERANS

A Profile of VA's Readjustment Counseling Program

CG 020446

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General Accounting Office
Washington, D.C. 20548

Human Resources Division

B-227618

August 26, 1987

The Honorable Frank H. Murkowski
Ranking Minority Member
Committee on Veterans' Affairs
United States Senate

Dear Senator Murkowski:

This report discusses the Veterans Administration's Readjustment Counseling Program in response to a request of the former Chairman of your Committee. We comment on the need to relocate the program's vet centers from their storefront locations to existing VA health care facilities. We also discuss program management issues and characteristics of veterans served by vet centers.

Copies of this report are being sent to the appropriate congressional committees; the Administrator of Veterans Affairs; the Director, Office of Management and Budget; and other interested parties.

Sincerely yours,

Edward A Densmore

for
Richard L. Fogel
Assistant Comptroller General

Executive Summary

Purpose

In fiscal year 1980, the Veterans Administration (VA) established the Readjustment Counseling Program to assist Vietnam era veterans who have not made a successful psychosocial adjustment to civilian life. The program was intended to make services available at vet centers for those veterans reluctant to seek counseling from regular VA health care facilities.

The former Chairman of the Senate Committee on Veterans' Affairs (Senator Alan Simpson) requested that GAO review specific aspects of the Readjustment Counseling Program to (1) evaluate the need for retaining vet centers in community-based locations; (2) provide information on the characteristics and problems of clients who have sought readjustment counseling; services provided; vet center staff qualifications; and centers' relations with VA medical centers, community programs, Vietnam veterans, and the public; and (3) assess program management, oversight, and recordkeeping.

Background

VA's Readjustment Counseling Service operates the Readjustment Counseling Program, which includes 188 vet centers around the country and costs, annually, about $40 million. The centers are in storefront locations in their communities, apart from established VA facilities. They provide counseling and other services to clients, the majority of whom are Vietnam era veterans. Most centers are headed by a team leader, with one to three counselors and clerical support.

By law, VA is required to take appropriate steps, during a 2-year period beginning October 1, 1987, to ensure the orderly transfer of the majority of vet centers from storefront locations to existing VA facilities. As of July 1, 1987, the Senate had passed legislation to postpone the beginning date by 1 year; the House of Representatives had passed legislation making the relocation optional rather than mandatory.

Each vet center is assigned to a VA support facility (usually a medical center), which provides administrative support. A vet center's staff is required to collaborate with its support facility staff on clinical issues. Thirteen VA medical centers have special inpatient units to treat veterans with post-traumatic stress disorder (PTSD), a clinical condition characterized by psychiatric symptoms that occur after military combat or exposure to other stressful events. The vet centers are required, when appropriate, to work closely with these units.

GAO obtained statistical information about client characteristics from the program's data base. GAO also mailed a questionnaire to all vet centers, made extensive site visits to 12 vet centers, observed staff and client activity at 6 additional centers, and reviewed the oversight activity at three of the program's seven regional offices. GAO's findings, based on the 12 centers, are not statistically representative of the entire program.

Results in Brief

Assuming the program can respond to changes in geographic factors and demands, GAO believes that VA should be able to decide on a case-by-case basis whether vet centers should be relocated to existing VA facilities. There were no compelling reasons, concerning the cost or quality of counseling services or veterans' access to them, for VA to be required to provide the services primarily through existing VA facilities.

There has not been a significant change in the personal characteristics of clients since the program began. Most served during the Vietnam era and appeared to have motivational or behavioral problems. For these problems, the centers offered an array of services, including individual and group counseling and employment and VA benefits assistance; the centers had established extensive community networks for outreach and referrals. Most centers' staffs had the academic, military, and professional experience that VA considered relevant, although many had been in their positions for less than 1 year.

Improved monitoring of centers' activities is needed to help ensure that they provide quality care.

Principal Findings

Future Location

Relocating vet centers to existing VA facilities will probably not significantly reduce program costs, and veterans' physical access to vet centers did not seem to be an issue. Veterans' use of services would decrease if the centers were relocated to existing VA facilities because of the veterans' distrust of VA (and other reasons), according to many veterans and vet center officials. The quality of the services could also be adversely affected by such a relocation, according to officials of VA and veterans' service organizations. Therefore, GAO believes VA should be allowed to decide on a case-by-case basis where vet centers are located. (See ch. 2.)

Client Characteristics

According to information obtained from VA's data base, over 305,000 clients had been seen at vet centers as of September 1985, the most recent data available at the time of GAO's review. The majority were unemployed white males, 31 to 40 years old, with at least a high school or equivalent education. Nearly 90 percent served in the military during the Vietnam era. Psychological (including anxieties and fears, low self-esteem, and survivor guilt), employment, or interpersonal problems were the ones the clients most frequently reported. The average number of new clients seen by each center has been increasing since fiscal year 1982 but has not yet reached the peak of fiscal year 1981. (See ch. 3.)

Staff Qualifications

The majority of team leaders and counselors had master's or doctoral degrees in social work, counseling, or counseling psychology, with more than 4 years of related professional experience. Most staff were Vietnam era veterans. Although the regional offices GAO visited conducted training as required, between one-quarter and one-half of newly hired team leaders indicated that they did not receive orientation training on many topics. (See ch. 5.)

Services Offered

The centers offered an array of counseling services, including individual and group counseling for veterans and their spouses, marriage and family counseling, and substance abuse counseling. Most centers also offered assistance for clients' problems with employment and general welfare, including obtaining VA benefits. In addition, some of the centers GAO visited sponsored therapeutic recreational activities for their clients. (See ch. 6.)

Outreach and Referral

Nearly all centers had a wide variety of services in their local areas to use for referrals. These services were provided by other VA facilities; veterans' organizations; and community social service, employment, and legal assistance agencies. In addition, centers used this network as a source of clients. However, officials at nine of the centers acknowledged that their follow-up of clients was often not done or was dependent on the judgments of individual counselors. (See ch. 6.)

Relations With Other VA Facilities

Centers routinely collaborated with their VA support facilities on administrative and clinical matters. However, only half of the centers located 80 or more miles from their support facilities had clinical collaborations in fiscal year 1985. Training was also adversely affected by distance.

Although nearly all centers identified clients needing inpatient PTSD care, most were not referred to a PTSD unit. Moreover, once a center referred a client to a unit, there was little contact between the two facilities to assure that the veteran received appropriate care. (See ch. 7.)

Management Problems

VA used several methods to communicate with and monitor the centers. However, regional program managers did not visit centers as frequently as required. Site visits were a critical mechanism for monitoring the services provided, but were not always conducted because of staff shortages and time demands. (See ch. 8.)

VA discontinued use of the program's data base in January 1986 because of a series of technical problems; therefore, many new clients seen during fiscal year 1985 were not documented in the data base. In addition, the data on certain contacts reported by vet centers were not consistent. Thus, the data are of little use for decisions about the need for particular centers. (See ch. 4.)

VA has not reviewed the quality of the counseling the centers provided. The program's regional staff reviewed clinical files during their site visits, but review procedures were not specific. GAO also questioned the adequacy of documentation in these files. (See ch. 9.)

Matter for Congressional Consideration

The Congress should consider permitting VA to decide on a case-by-case basis whether to move the centers from their current locations.

Recommendations

GAO is making several recommendations to improve management and oversight of the Readjustment Counseling Program.

Agency Comments

In a letter dated June 11, 1987, the Administrator of Veterans Affairs endorsed GAO's matter for congressional consideration. The Administrator said this would permit VA to consider each center's changing needs and the method and location best suited to meeting those needs. The Administrator also concurred with the GAO recommendations to improve the program's management and oversight and described a number of actions that VA has taken and plans to take.

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Abbreviations

GAO	General Accounting Office
PTSD	post-traumatic stress disorder
VA	Veterans Administration
DM&S	Department of Medicine and Surgery

Chapter 1

Introduction

In fiscal year 1980, the Veterans Administration (VA) began the Readjustment Counseling Program, opening community facilities, known as vet centers, to assist Vietnam era veterans'[1] adjustment to postwar civilian life. The veterans' families and "significant others"[2] could also be assisted, if necessary, in dealing with veterans' adjustment. Many veterans who served in Vietnam experienced readjustment problems resulting in family difficulties, unemployment, alcohol or drug dependency, and other forms of social or economic impairments. These veterans were often reluctant to seek evaluation or treatment from established VA facilities. The Readjustment Counseling Program was designed to overcome this reluctance by making VA's mental health services available to these veterans on an outpatient, storefront basis, avoiding the implication of mental illness. As of April 1987, 188 vet centers had been opened.

The services provided at the centers normally have included individual and group counseling; assistance with employment, military discharge, and VA benefits; and referrals to community and government agencies. Under certain circumstances, VA has provided readjustment counseling services to veterans through contracts with private providers. With the exception of those who received dishonorable discharges, all veterans who served during the Vietnam era (Aug. 1964-May 1975) are eligible for the program's services. In fiscal year 1985, VA spent $38.7 million for the program, including $7.3 million for services provided by private providers under contract to VA. The budget for fiscal year 1987 was $40.7 million, including $5.6 million for contracts.

Program Background

The program was authorized by the Veterans' Health Care Amendments of 1979 (Public Law 96-22, June 13, 1979). The Congress amended the legislation three times (Public Law 97-72, Nov. 3, 1981; Public Law 98-160, Nov. 21, 1983; and Public Law 99-576, Oct. 28, 1986). See Chapter 2 for a discussion of the effect of these amendments on relocation of the Readjustment Counseling Program from one based in storefront locations to one based primarily in existing VA facilities.

In fiscal year 1985, the Congress directed VA to allocate an additional 220 staff years to (1) expand the Readjustment Counseling Program by augmenting staff at existing centers and (2) establish new centers at locations with the greatest need. VA used most of the additional staff years to establish 52 new centers. No further expansion is planned.

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[1] Although the readjustment problems were generally attributed to veterans who had experienced combat in Southeast Asia, the program is available for any veteran who served during the Vietnam era.

[2] A term used to designate anyone other than a spouse or child who is significant in the veteran's life. The term can include the veteran's girlfriend or boyfriend, other close friends, and parents.

Program Structure and Organization

The Readjustment Counseling Program is managed by the Department of Medicine and Surgery's (DM&S's) Readjustment Counseling Service at VA's central office. The Readjustment Counseling Service director reports to DM&S's director for Operations and is assisted by a staff, including two field managers (not located at the central office) responsible for the oversight of the professional aspects of the program.

The director has delegated much of the management responsibility to the seven program regional offices.[3] Generally, each regional office is headed by a regional manager and includes a professional staff consisting of a deputy regional manager and associate regional managers for Administration and Counseling. The staff responsibilities include monitoring how the centers deliver services, training program staff, enhancing relations with other VA facilities, and assessing program performance.

The 188 vet centers operate within the program's regional structure. Most are headed by a team leader, with two to three counselors and clerical support. Twenty-seven of the centers are satellites; they generally have smaller staffs and are headed by a coordinator who reports to a team leader at another center. Vet centers also rely on volunteers, work-study students, and other supplementary staff. Although located apart from established VA facilities, each vet center is administratively assigned to a VA support facility (usually a medical center), which provides such services as purchasing supplies, paying the bills, and maintaining the payroll. Vet centers and their support facilities are also expected to collaborate on clinical and other professional matters.

Objectives, Scope, and Methodology

The former Chairman of the Senate Committee on Veterans' Affairs (Senator Alan Simpson) requested that we examine specific aspects of the Readjustment Counseling Program. We subsequently agreed with the

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[3] These regional offices are distinct from the regional offices for both VA's DM&S and its Department of Veterans Benefits. When we began our review, there were six program regional offices. The regions were subsequently realigned, and a seventh was established on July 1, 1986.

Chairman's office to review the (1) need to retain the centers in community-based locations; (2) number, characteristics, and problems of veterans who use vet centers; (3) services provided by the centers and the qualifications and training of the staff; (4) management, oversight, and recordkeeping of the program; (5) centers' coordination with post-traumatic stress disorder[4] (PTSD) units; and (6) centers' relations with VA medical centers, community treatment programs, veterans, and the public. (App. I includes the Chairman's request letter.)

Our report provides detailed information on the above issues, but does not address program effectiveness. Although the Chairman requested us to assess effectiveness, we agreed with his office not to do so because VA was preparing reports on the program's effectiveness and on the frequency of certain psychological and readjustment problems in the Vietnam theater veteran population as compared with Vietnam era nontheater veterans and nonveterans. The first report, issued on July 9, 1987, concluded that the program has been effective and successful.

To accomplish our objectives, we visited the Readjustment Counseling Service in VA's central office, three of the program's regional offices, four vet centers in each of those three regions, and the VA support facility for each center visited (see table 1.1). We also interviewed representatives from several veterans' organizations.

Table 1.1: Regional Offices, Vet Centers, and Support Facilities

Regional office	Vet center	Support facility[a]
Providence, RI (region I)	Springfield, MA Bangor, ME Pawtucket, RI Boston, MA	Northampton, MA Togus, ME Providence, RI Boston, MA
Bay Pines, FL (region III)	Greenville, SC Jackson, MS St. Petersburg, FL Knoxville, TN	Columbia, SC Jackson, MS Bay Pines, FL Nashville, TN
Los Angeles, CA (region VI)	San Jose, CA Las Vegas, NV Oakland,CA Albuquerque, NM	Palo Alto, CA Las Vegas, NV Martinez, CA Albuquerque, NM

[a] All support facilities visited were medical centers except the one in Las Vegas, which was an outpatient clinic.

Between January and June 1986, we visited the 12 centers. All had been operating before December 31, 1983. We selected some located in urban areas and some in rural areas, some geographically close to their support facilities and some geographically distant. We also selected three centers affiliated with medical centers that housed PTSD units and one center whose support facility was an outpatient clinic. In addition, we included centers serving areas with significant minority populations. To the extent practical, the above characteristics were represented in our sample in the same proportion they were represented in all centers that opened before December 31, 1983. Although we believe that the offices, vet centers, and support facilities we reviewed (table 1.1) represent a valid cross section, our findings cannot be projected to the entire program (including 7 regional offices, 188 vet centers, and the related support facilities).

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[4] Post-traumatic stress disorder is a syndrome that a person may develop after having experienced a severely stressful or traumatic event. It is more fully described in chapter 7.

At VA's central office and each regional office visited, we interviewed program managers about program requirements as well as their oversight responsibilities and views on the continued need for community-based locations. We also examined program guidance[5] and monitoring reports.

To determine whether there was a continuing need for retaining the vet centers in their storefront locations, we (1) reviewed the legislative history of the Readjustment Counseling Program and (2) discussed the issue with the director of the Readjustment Counseling Service, officials at the vet centers and support facilities we visited, and representatives of veterans' service organizations. We also solicited the opinions of vet center clients during our visits to the 12 vet centers.

At each vet center, we interviewed the team leader and other center staff on all facets of the program; reviewed pertinent documentation, including a sample of clinical records; observed center activities; contacted local government and community service agencies; and obtained clients' views on the preferred location for the Readjustment Counseling Program. At each vet center's support facility, we interviewed appropriate officials to discuss administrative and clinical relations between the two facilities.

In addition to the above site visits, we made 1-day unannounced visits to six centers to observe the activities of clients and staff. The centers visited were in Avon and Brighton, Mass.; Baltimore, Md.; Oak Park, Ill.; Reno, Nev.; and Concord, Calif. Generally, these centers were selected because they were convenient for our staff. The results of these visits are not projectable to these vet centers or the program.

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[5] This term refers to the 1982 Program Guide, issued by the Readjustment Counseling Service, as well as various policy memoranda and other communications issued to vet centers and regional offices.

To supplement our site visits, we mailed a questionnaire to all vet centers to obtain information mainly about the staff and the centers' fiscal year 1985 activities. All centers responded to the questionnaire. We also obtained statistical information about program clients from the program's computerized data base.[6] To assess the accuracy of the data base, we randomly selected and reviewed a total of 100 client files from the 12 centers visited. We compared the source documents in each file with information in the data base. To determine how the documents were prepared, we interviewed center staff who completed the source documents; we also interviewed central office and regional office managers about their perceptions of the data base accuracy.

Appendix II describes some characteristics of vet centers as reported in responses to our questionnaire. Appendix III describes our questionnaire design and methodology, and appendix IV describes the methodology used to sample client files and determine the data base accuracy. (Ch. 4 includes our assessment of the data base accuracy.)

Our review, done between March 1985 and August 1986, was in accordance with generally accepted government auditing standards.

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[6] The computerized data base was discontinued in January 1986 and replaced by a manual system in October 1986.

Chapter 2

VA Should Have More Flexibility in Deciding Where Vet Centers Are Located

The major issue the former Chairman of the Senate Committee on Veterans' Affairs asked us to address is the need for retaining the vet centers in storefront locations. Current law requires that, by October 1, 1989, the Readjustment Counseling Program be based "primarily" in VA medical centers. In enacting the initial legislation requiring the relocation of vet centers, the Congress recognized the need for some flexibility for VA in deciding on the location of vet centers. The law allows vet centers to remain in storefront locations on an exception basis, such as where there is a substantial demand for readjustment counseling services and the VA medical center could not absorb the counseling workload. Recently, the Senate Committee on Veterans' Affairs, in advocating an extension of the relocation date, adopted the following position, taken by VA's general counsel: the "primarily" criterion requires that by the end of the relocation period a majority of vet centers must be operated at existing VA facilities. The House, on the other hand, passed legislation making the relocation optional rather than mandatory.

We reviewed the reasons for the establishment of the vet centers; opinions of VA and veterans' service organization officials on the vet centers' location; and the effect a change in the program would have on the cost, quality, and availability of services. Based on this review, we believe that VA should be able to decide on a case-by-case basis where vet centers are located. There does not appear to be much to gain by moving vet centers to VA medical centers. The requirement that services be provided "primarily" through traditional VA facilities limits VA's flexibility to judge the location of each center on its own merits, even if "primarily" is interpreted to mean "majority." Therefore, we believe the Congress should consider permitting VA increased flexibility to decide whether to relocate vet centers.

Legislative History of the Requirement to Relocate Vet Centers in Existing VA Health Care Facilities

The vet center concept was designed to overcome the reluctance of many Vietnam era veterans to seek counseling for their readjustment problems from the VA system. Although the original legislation (Public Law 96-22, June 13, 1979, codified as 38 U.S.C. 612A) did not specify that the program was to be operated through storefront locations, VA informed the authorizing committees of its intention to do so:

> "The readjustment counseling programs will be located in the local communities with easy access for the Vietnam era veteran population. They can operate from independent store fronts, college campuses, offices within community mental health centers and offices within other sympathetic organizations." (Hearings before the Senate Committee on Veterans' Affairs, Jan. 25, 1979)

The 1981 amendments to the original legislation (Public Law 97-72, Nov. 3, 1981) called for the relocation of the Readjustment Counseling Program from a storefront-based program into one based "primarily" in existing VA health-care facilities.[1] The relocation was to take place during fiscal year 1984. In its report on that legislation, the House Veterans' Affairs Committee said it wanted closer supervision by the VA medical center directors and chiefs of staff; the Committee indicated, however, that it was not opposed to a continuance of the storefront program. Nevertheless, VA noted:

> "While there were sound reasons for implementing VA's readjustment counseling authority through a community-based delivery and referral mechanism, it was never intended that the Outreach Center be other than a short-term facility. Nor was it intended to be offered indefinitely." (Letter to the Chairman, House Committee on Veterans' Affairs, Apr. 9, 1981)

According to the statement explaining the compromise agreement, VA would not be prohibited from continuing to operate some vet centers after the relocation date,

> "particularly in areas where the demand on the vet center is expected to remain at a high level and the other VA health-care facilities in the immediate area would not be able to absorb easily a significant increase in demand for services."

The 1983 amendments (Public Law 98-160, Nov. 21, 1983) extended the relocation period to fiscal year 1988; the 1986 amendments (Public Law 99-576, Oct. 28, 1986) extended it to fiscal year 1989 and provided that the relocation take place in an "orderly and gradual" manner over the course of 2 years, rather than 1 year.

The current Congress has before it several legislative proposals on both the timing and nature of the relocation of vet centers to existing VA health-care facilities. Section 201 of S. 477, passed by the Senate on March 31, 1987, would provide for a 1-year postponement (from Sept. 30, 1989, to Sept. 30, 1990) of the date by which the Readjustment Counseling Program would complete the relocation. The legislation would also require that the program provide readjustment counseling services "primarily" through existing VA health-care facilities. In discussing the legislation, the Chairman of the Senate Committee on Veterans' Affairs said that his Committee agreed with the interpretation of

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[1] We use the term "existing VA health-care facilities" to refer to what the law calls "the health care facilities operated by the Veterans Administration for the provision of other health care services." These facilities include the 172 VA medical centers and 58 outpatient clinics not located at medical centers.

VA's general counsel that the "primarily" criterion requires that by the end of the period a "majority" of vet centers must be operated at traditional VA facilities. On August 7, 1987, the Committee's Ranking Minority Member introduced S. 1646; section 301 of this proposal would also postpone for 1 year the date by which the relocation should be completed.

On July 15, 1987, the Committee Chairman and 10 other Senators introduced S. 1501 that would, among other things, replace the relocation provision of the existing law with one permitting closing or relocation of a vet center only on the following determination by the chief medical director, based on the application of certain criteria: that such a closing or relocation would not result in any diminution in the continuing availability and effective provision of readjustment counseling needed by veterans and others entitled to such services in the geographic area.

H.R. 2616, passed by the House on June 30, 1987, would (1) make the relocation of vet centers optional rather than mandatory, and (2) require that VA operate the same number of free-standing vet centers on October 1, 1988, that it operated on April 1, 1987. VA had announced plans to relocate nine vet centers to VA medical centers during fiscal year 1987 because, according to the chief medical director, "it would be wise to proceed with this small-scale relocation . . . to allow the agency to gain experience and information which will be useful in planning the full transition required by law." On June 29, 1987, the U.S. District Court for the District of Columbia, acting on a suit filed by the Vietnam Veterans of America, enjoined VA from closing the centers.

DM&S Plans to Keep Vet Centers in Storefront Locations

None of the vet centers are located in existing VA health-care facilities. About 45 percent of the centers are housed in multioffice commercial space, 31 percent in single-office commercial buildings, 14 percent in residential settings, 6 percent in shopping centers, and the remainder in other settings.

In July 1984, VA's chief medical director established the Vet Center Planning Committee to develop options for the future of the centers. The committee, a DM&S group comprised of VA central office and field managers, considered five options:

- Option I: Continue the present system after fiscal year 1988, with no major alterations in organizational structure, services offered, or eligibility. Phase down the contracts portion of the program, redirecting those resources into existing centers. Adjust center resources, closing down centers or relocating them in VA medical centers or outpatient clinics, if appropriate, based on changes in geographic factors and demand. Reduce management units.

- Option II: Convert the centers during fiscal year 1988 into general outpatient clinics or community-based centers by adding services such as specialized counseling and medical and surgical services.
- Option III: Beginning in fiscal year 1988, integrate centers into psychiatry services and decide the centers' locations as appropriate.
- Option IV: Defer the decision until 1987. In the meantime, conduct a pilot program to test a model for merging vet center services with other DM&S services.
- Option V: Incorporate the Readjustment Counseling Program as a professional service under the chief of staff of VA medical facilities and decide on appropriate locations. Place the program regional staff under the DM&S regional director.

In December 1985, the committee recommended option I. A major aspect of this option was deciding on the location of an individual vet center, based on that center's changing pattern of utilization. According to the report, "Relocations may include locating a Vet Center within a VAMC [medical center] or VAOPC [outpatient clinic] if desirable according to local patterns of utilization." The committee stated that the Readjustment Counseling Program had been highly successful and effective, becoming an "integral and complementary part of the overall VA health care delivery system." According to the committee, this success was a result of the highly committed and compassionate staff and the program's cost-effectiveness; in addition, the current organizational structure had "probably significantly decreased morbidity and need for hospitalization."

The committee recognized that although utilization of services in the vet centers had not shown any significant decrease, "the current organizational structure of the program lends itself readily to downsizing at whatever rate is indicated by a future decline in need for services."

On February 21, 1986, the chief medical director approved option I.

Potential Effects of Relocating Vet Centers

We assessed the retaining of vet centers in storefront locations in terms of the potential effect of any change in location on the cost and quality of the care offered, as well as on veterans' access to that care. We found that (1) the relocation would probably not have a significant effect on program costs; (2) veterans' access to readjustment counseling would probably not be significantly affected, but their willingness to seek that care might be lessened if the vet centers were absorbed into existing VA facilities; and (3) according to many officials we interviewed, the quality of readjustment counseling would be adversely affected if the vet centers were relocated to existing VA facilities and the medical center staff provided the counseling instead of the vet center staff.

Cost

Relocating the vet centers to existing VA facilities will probably not have a significant effect on program costs. Overall, program funding is not expected to grow, remaining at about $40.5 million through fiscal year 1989. Salaries, the major program expense, were about 63 percent of the cost in fiscal year 1985. Staffing is expected to remain at 794 full-time employee equivalents through fiscal year 1989.

Space rental and utility costs currently being incurred (about $3 million according to the program director) would be avoided if existing VA facilities had extra space so that they could absorb the vet centers. If the receiving facilities could not physically absorb the vet centers, however, the facilities would have to incur additional costs to provide space (either by providing temporary quarters, such as in a trailer, or by leasing space in a nearby building).

We did not obtain data on the costs incurred by individual vet centers because these data are maintained by the vet centers' support facilities and, when the support facility has more than one vet center, costs cannot easily be identified with a particular center. For example, of the 12 vet centers we reviewed, 9 are connected to support facilities that serve more than one center. Of the nine support facilities, only one classified its costs so that all costs attributable to each center could easily be identified.

Access

VA officials we interviewed were divided in their opinions about whether relocating vet centers to existing VA facilities would adversely affect the access of most veterans to needed services. The majority of officials agreed, however, that the number of veterans willing to accept counseling would drop if the vet centers relocated.

At the 12 vet centers we visited, we asked the team leaders for their opinions on the effect of relocating their centers to existing VA facilities.

Six said the relocation would reduce the number of veterans conveniently located near a vet center; this is so because the veterans would have to travel farther or to locations not served by public transportation; six said the relocation would not reduce the number. We posed the same question to nine of the liaison officers at the vet centers' support facilities. Three agreed that relocating the program to their facilities would reduce access, and six disagreed.

DM&S assumes that 50 miles (one way) is the maximum most veterans can be expected to drive for weekly visits. According to the Readjustment Counseling Service director, there were 44 vet centers whose distance from the closest existing VA medical center would be great enough to discourage current vet center clients from using the service if the centers relocated.

The number of veterans willing to accept counseling services would drop, according to all 12 team leaders and 7 of the 12 liaison officers we interviewed, if the vet centers moved to existing VA facilities. These officials attributed this mainly to the veterans' distrust of the VA, VA's lack of experience with and understanding of Vietnam veterans' problems, the perceived cold and impersonal environment at existing VA facilities, and veterans' perceptions that if they go to an existing VA facility they will be viewed as having a "sickness." The program director told us, however, that he has seen an improvement in the willingness of Vietnam era veterans to seek counseling at existing VA facilities, but the change has been slow.

To determine how clients felt about the issue of locating the vet centers in existing VA medical centers, we did a nonscientific, nonprojectable survey of clients who visited the 12 vet centers during our visits. Of the 328 clients we surveyed, 53 percent said they would go to the vet center if it was located at the nearest VA facility and run by vet center staff; 43 percent said they would not go. Thirty-two percent said they would go to a VA facility even if the program was run by the VA facility staff rather than the vet center staff; 63 percent said they would not. The remaining clients did not express a definitive opinion.

Quality

According to the officials of VA and veterans' service organization that we interviewed, the quality and effectiveness of counseling services could be adversely affected by relocating the vet centers to the existing VA facilities. Several veterans' service organization representatives and VA officials told us that attitudes, both of veterans and other VA facility staff, would tend to reduce the effectiveness of the program, in terms of veterans' willingness to seek needed counseling and the quality of that counseling, if the centers were relocated to existing VA facilities under a different organizational structure.

VA officials told us that if vet centers were moved to existing VA facilities, the Readjustment Counseling Program would lose its autonomy; counselors would incur many restrictions concerning their relations with clients (such as would be required in following a "medical approach"), and the program would no longer be a priority. The program director told us the following: Relocating the vet centers to existing VA facilities could be detrimental to the quality of counseling services at some centers. If the vet centers became part of the psychiatry service (option III), quality could decrease. The psychiatry service has several missions, but the Readjustment Counseling Program has only one; therefore, the uniqueness of the program would disappear. Incorporating most centers as an independent service reporting to the chiefs of staff (option V) could also negatively affect the quality and effectiveness of the program.

Eleven of the 12 team leaders told us that the quality of services would decrease if center staffs were absorbed by the existing VA facilities, becoming part of the psychiatry service. One team leader felt that quality would increase with the relocation. Nine of the team leaders felt that quality would suffer if the vet center staffs were placed under the control of the chief of staff.

The ten liaison officers we questioned were split in their opinions about the effect relocating vet centers would have on the quality of counseling provided. Six agreed that placing vet center staffs under the psychiatry service would negatively affect the counseling services; four disagreed. Six liaison officers agreed that placing vet center staffs under the chiefs of staff would negatively affect counseling services; three disagreed, and one felt there would be no effect.

Conclusions

There does not appear to be much to be gained by requiring that vet centers be relocated to existing VA facilities. Costs would not be significantly reduced; some veterans' willingness to seek counseling could be adversely affected; and, according to the majority of officials we interviewed, the quality of the counseling could suffer.

Therefore, we believe that VA ought to be able to decide on a case-by-case basis whether vet centers should be relocated to existing VA facilities, given these program conditions: (1) if the program has proven to be an effective mechanism for caring for the readjustment problems of veterans and (2) if VA can adjust center resources to respond to the growing or diminishing needs for their services. Section 107(d) of H.R. 2616, passed by the House on June 30, 1987, or section 3(3) of S. 1501, introduced on July 15, 1987, would provide VA flexibility in deciding whether to relocate individual vet centers to existing VA health care facilities. Section 201 of S. 477 and section 301 of S. 1646 would give VA more time to take appropriate relocation actions.

Matter for Consideration by the Congress

The Congress should consider permitting VA to decide on a case-by-case basis whether to relocate vet centers from storefront locations to existing VA facilities.

Agency Comments

In a letter dated June 11, 1987, the Administrator of Veterans Affairs endorsed our position. According to him, permitting VA to determine whether or not to relocate a vet center to an existing VA health care facility on a case-by-case basis would permit VA to consider each center's changing needs and the method and location best suited to meeting those needs.

Chapter 3

Characteristics of Clients Served by the Readjustment Counseling Program

The clients served by the Readjustment Counseling Program generally fit the profile of those veterans the Congress intended the program to serve. Most had been in the military during the Vietnam era. The majority were unemployed and did not have a bachelor's degree. About half of them were divorced, separated, or had never been married. For the most part, their problems (notably, interpersonal, employment, and financial or housing) reflected this profile. However, counselors judged over one-quarter of clients' problems to be unrelated to their military service. Moreover, although some clients had numerous contacts with staff members, the majority did not sustain contact.

The statistics cited in this chapter are from VA's computerized program data base, which describes the number and characteristics of clients served. VA maintained the data base from the program's inception until January 1986. The statistics presented here are as of September 1985, the most recent data available at the time of our review. We assessed the data base accuracy, concluding that the number of clients served and client contacts made were questionable. The results of our assessment of the data base are described in chapter 4.

Vet Centers Served Over 305,000 Clients

According to the data base, 305,000 clients had been seen in vet centers.[1] The average number of new clients seen increased between fiscal years 1982 and 1984, but did not reach the peak of fiscal year 1981, as illustrated in figure 3.1.

To fairly represent client workload, these figures exclude centers during the years they were not fully operational. The number of clients seen was relatively high in fiscal year 1981 because staff may have spent more time attracting clients than treating them, the program director suggested.

Fiscal year 1985 was not included in figure 3.1 because a large number of clients were probably not documented in the data base that year (see ch. 4). However, based on the centers' manual counts of clients seen during a 9-month period in fiscal year 1985, we projected that the average number of clients seen that year per center was 486.

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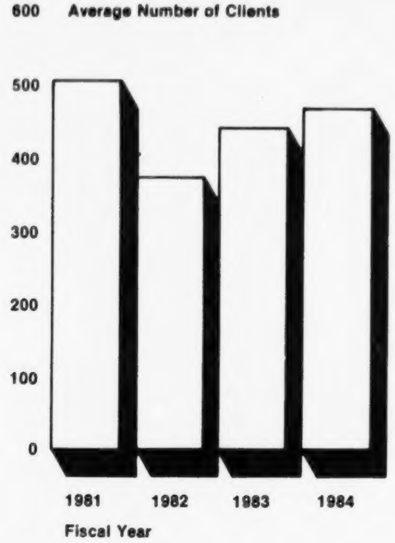
[1] This is out of a total Vietnam era veteran population of 8.3 million.

Figure 3.1: Average Number of New Clients Seen Per Vet Center (Fiscal Years 1981-84)



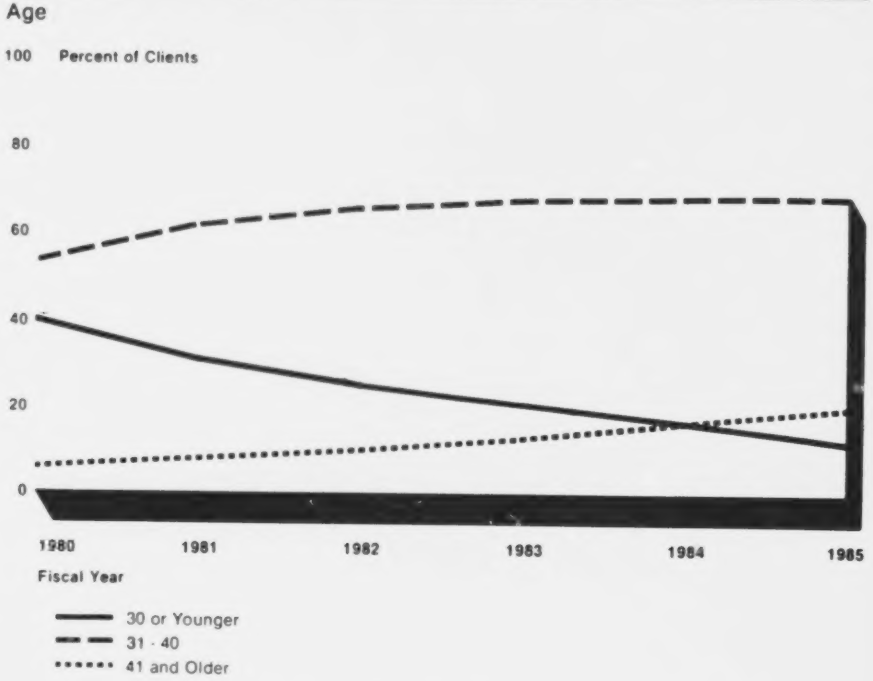
Source: VA Readjustment Counseling Program data base.

Client Profile Changed Slightly Since the Beginning of the Program

Ninety-eight percent of all clients in the data base who came to vet centers were male. The characteristics of the client profile for those who first visited vet centers in the program's more recent years changed slightly from those of clients whose first visit was during the earlier years, as shown in figures 3.2 to 3.6.

The median age of new clients was generally consistent with the median age, as of September 1984, of all Vietnam era veterans. In addition, approximately the same percentage of female veterans came to vet centers as served during the Vietnam era. However, as compared with all Vietnam era veterans, the vet centers saw a proportionally higher number of black veterans (9 percent of all Vietnam era veterans were black), unemployed veterans (the average monthly unemployment rate for male Vietnam era veterans between January 1980 and September 1984 was 7.1 percent), and veterans with less than 4 years of college (about 22 percent of male Vietnam era veterans had 4 years or more of college as of the early 1980's).

Figure 3.2: Readjustment Counseling Program Client Profile—Age (Fiscal Years 1980-85)



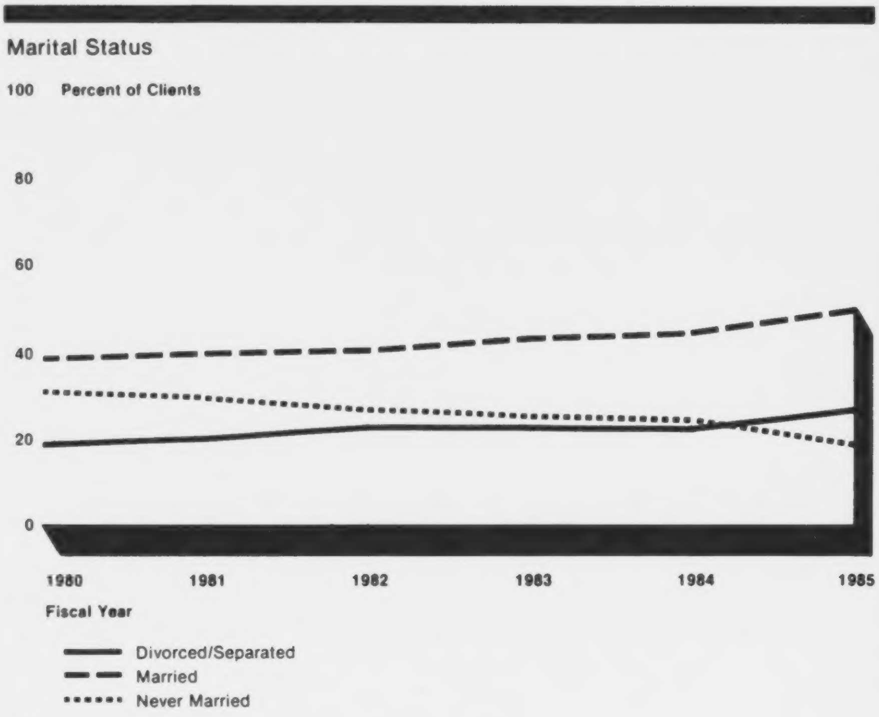
Source: VA Readjustment Counseling Program data base.

Clients Generally Vietnam Era Veterans

The program's authorizing legislation states that the Readjustment Counseling Program is intended for veterans who were on active duty during the Vietnam era. Eleven percent of vet center clients did not serve during that period. The program director said that he, the regional managers, and the deputy regional managers he talked to expected that percentage to be lower. He said, however, that if a non-Vietnam era veteran, especially one who served in combat, had significant psychological problems, then counselors had a moral responsibility to assist that veteran a few times. The director added that non-Vietnam era veterans with no significant problems should have been referred elsewhere.

We could not determine from VA's data base the percentage of clients who served in a combat status. The data base did indicate that 56 percent of clients served in combat; the remainder either did not serve in

Figure 3.3: Readjustment Counseling Program Client Profile—Marital Status (Fiscal Years 1980-85)



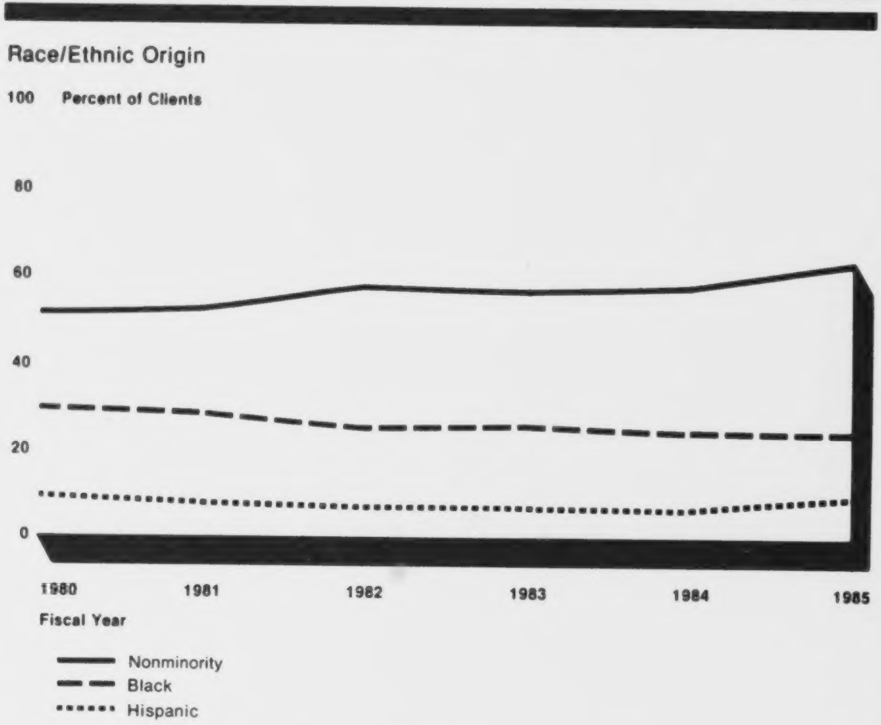
Source: VA Readjustment Counseling Program data base.

combat or did not have that information recorded. However, until fiscal year 1985 the data base did not distinguish between these clients.

Combat service was never precisely defined: Until fiscal year 1985, vet center staff were instructed that discretion should be used in determining combat service since any service in Vietnam could be considered combat. In fiscal year 1985, combat service was defined as service in a "war-zone theater." The Vietnam theater included Vietnam, Laos, Cambodia, and their contiguous waters and air space.

We also could not determine from the data base the total percentage of clients who had service-connected disabilities. The data base indicated that 23 percent of clients had a service-connected disability, and the remainder either did not have a service-connected disability or did not have that information recorded. Again, the data base did not distinguish between these clients.

Figure 3.4: Readjustment Counseling Program Client Profile—Race/Ethnic Origin (Fiscal Years 1980-85)



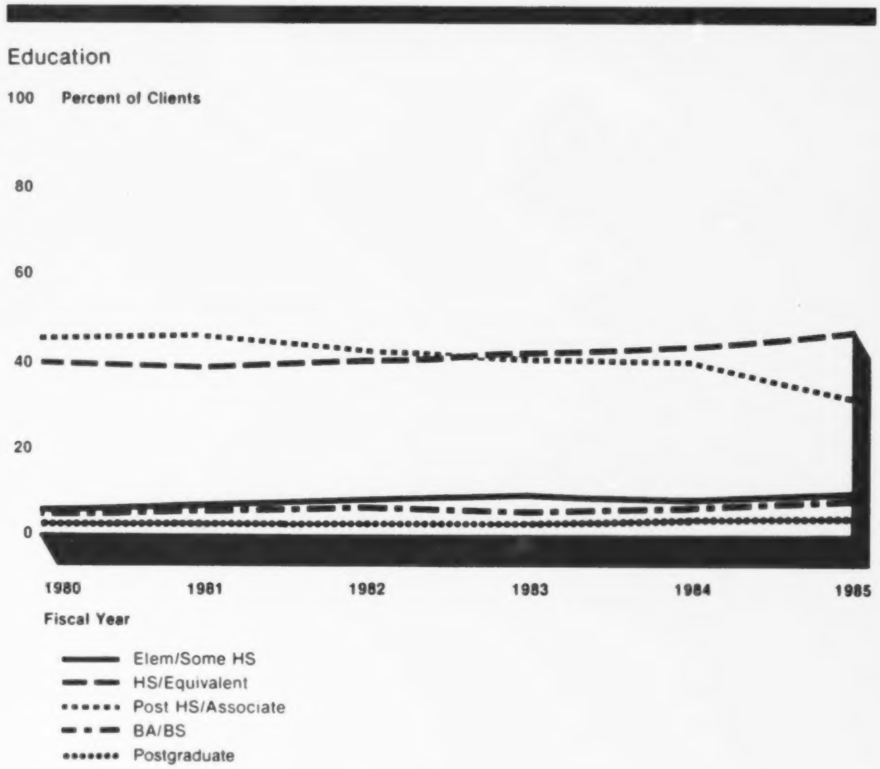
Source: VA Readjustment Counseling Program data base.

During our visits to six vet centers to observe staff and client activity, we asked staff at each center to record, for all clients who came to the center on the day of our visit, whether the client (1) experienced hostile fire in combat situations in Southeast Asia and (2) had a service-connected disability. Of the 47 clients from whom the staff obtained this information, 37 had experienced hostile fire and 14 had service-connected disabilities. Of the 14 clients who had service-connected disabilities, 5 came to the center that day for a problem related to the disability.

Clients Had Motivational or Behavioral Problems

The Readjustment Counseling Program was established to deal with interpersonal (low-grade motivational or behavioral impairments affecting veterans' normal interpersonal relationships), employment (job or educational performance), or psychological (overall ability to cope reasonably effectively with daily life) problems. Most veterans seen at vet

Figure 3.5: Readjustment Counseling Program Client Profile—Education
(Fiscal Years 1980-85)



Source: VA Readjustment Counseling Program data base.

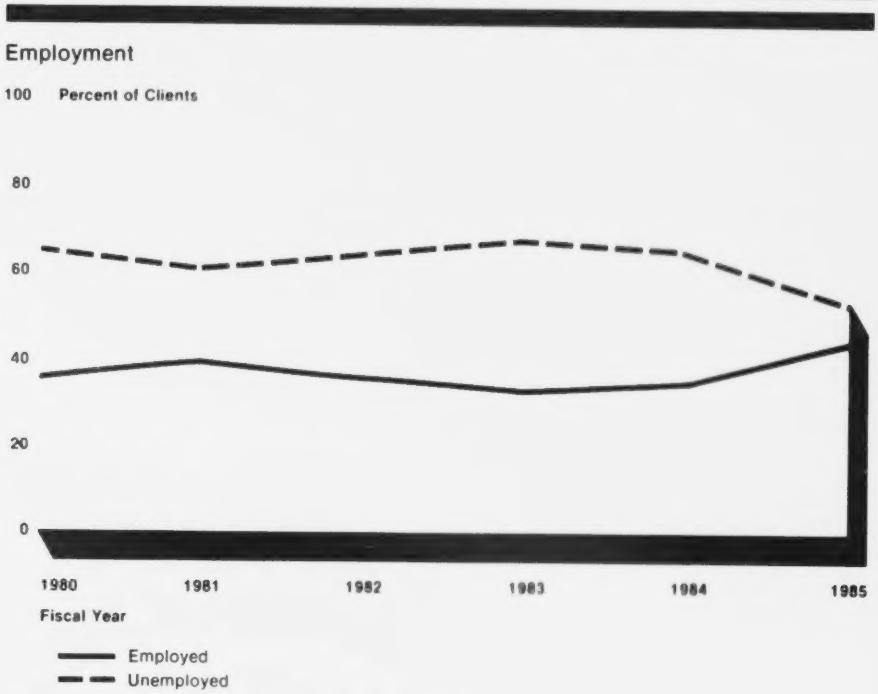
centers appeared to exhibit these problems. The problems counselors most frequently reported their clients had during a first visit to a vet center are shown in figure 3.7.

Clients' Problems Often Judged Unrelated to Military Service

In fiscal year 1985, staff at the vet centers reported that, overall, 49 percent of clients' problems were military-related, and 27 percent were not. The staff could not determine whether the remaining 24 percent of problems were military related. The problems were categorized as follows:

- PTSD: Includes symptoms such as intrusive recollections of a traumatic event, loss of interest in significant activities, sleep disturbances, trouble concentrating, and easily startled.

Figure 3.6: Readjustment Counseling Program Client Profile—Employment (Fiscal Years 1980-85)

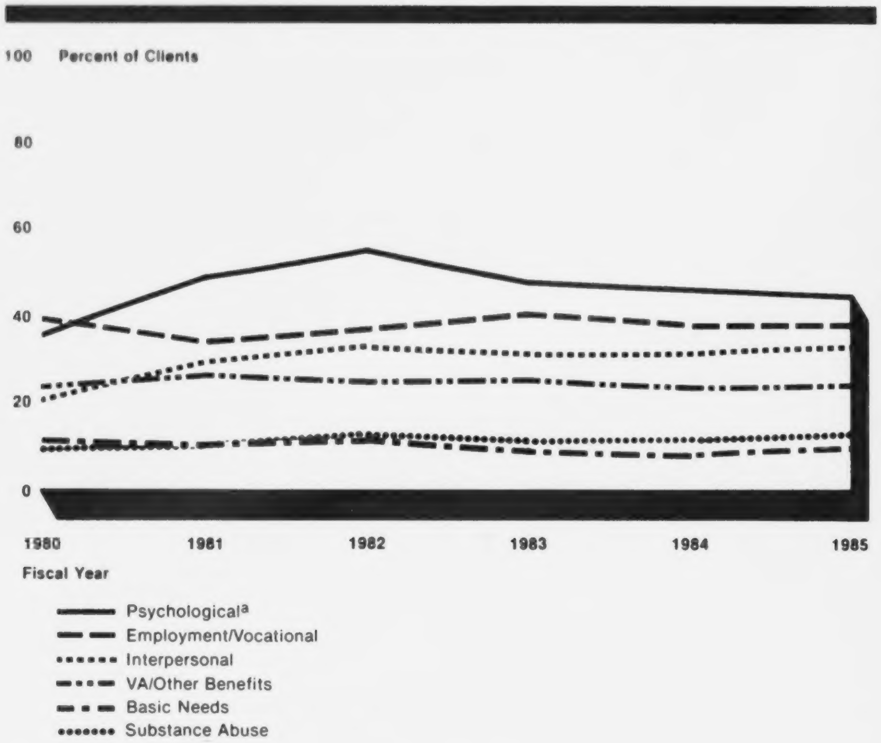


Source: VA Readjustment Counseling Program data base

- Post-trauma symptoms: Includes symptoms that do not indicate PTSD but are related to an identifiable stressful event.
- Substance use disorder: Includes the abuse of or dependence on alcohol or drugs.
- Psychosocial problems: Includes problems, such as marital difficulties, that are not mental disorders but do indicate a need for counseling or psychotherapy.
- Noncounseling problems: Includes problems that require technical assistance, education, referral, or other noncounseling assistance, such as information about a discharge upgrade.
- Other problems: Includes undefined psychiatric disorders, anxiety, and antisocial behavior or other personality disorders.

With the exception of PTSD and post-trauma symptoms, counselors reported many problems as being unrelated to clients' military service, as shown in figure 3.8.

Figure 3.7: Reported Client Problems
(Fiscal Years 1980-85)



Source: VA Readjustment Counseling Program data base.

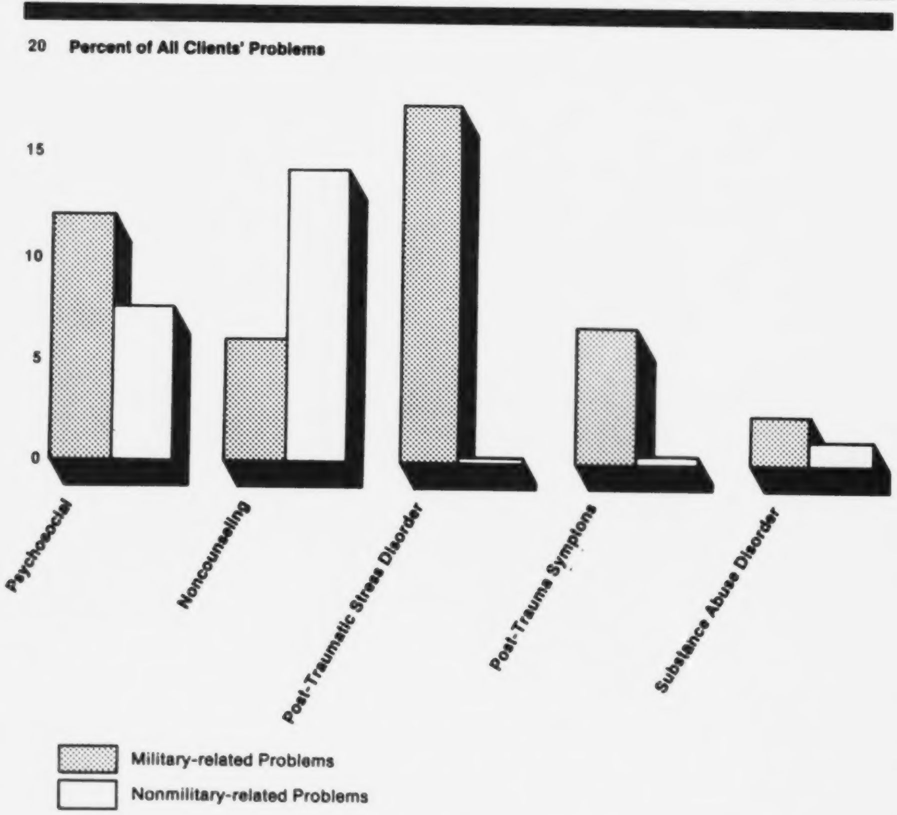
[a]Psychological problems include anxieties and fears; bad dreams, flashbacks, and intrusive recollections of a traumatic event; suicidal or homicidal behaviors, memory impairment; depression; low self-esteem; aggressive behavior; wandering life-style; loss of interest in significant activities; and survivor guilt.

Most Clients' Relations With Vet Centers Short-Lived

In fiscal year 1985, half of all clients who came to a vet center that opened before October 1, 1984, were new clients that year. Moreover, the proportion of new clients who had three or fewer contacts with a center grew almost every year, as shown in figure 3.9.

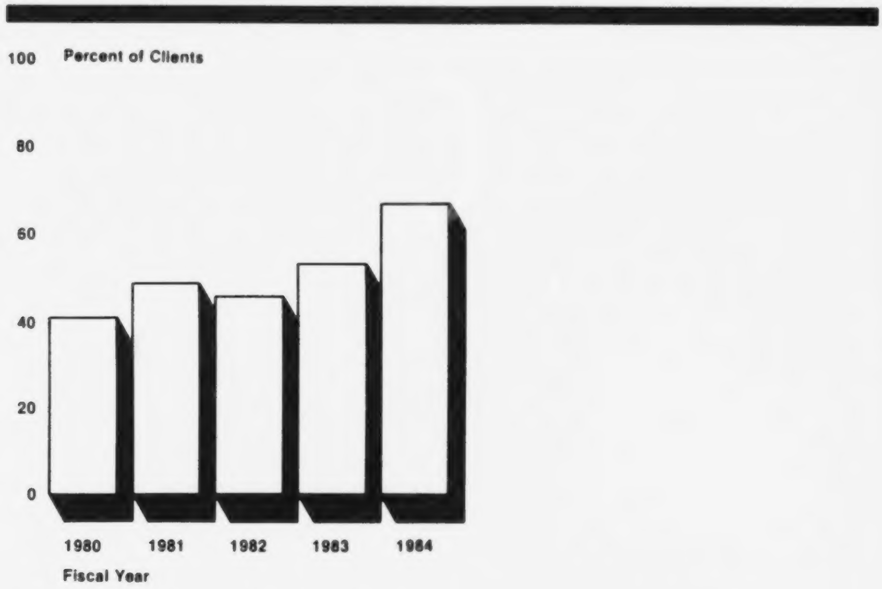
Fifty-five percent of the clients who, on the day of our visit, came to the six centers we observed had first come to that center within the previous year. Eleven percent of the clients made their first visit that day. On average, the clients had visited the center 15 times during the previous 6 months.

Figure 3.8: Clients' Problems and Relation to Military Service
(Fiscal Year 1985)



Source: VA Readjustment Counseling Program data base.

Figure 3.9: New Clients With Three or Fewer Vet Center Contacts
(Fiscal Years 1980-84)



Source: VA Readjustment Counseling Program data base.

Accuracy of Readjustment Counseling Program Data Base Questionable

The Readjustment Counseling Program's computerized data base was established in fiscal year 1980 to (1) collect information for statistical analyses of Vietnam veterans, (2) generate management reports, and (3) determine the continued need for vet centers in particular locations. It is the most extensive single source of information about the number and characteristics of clients who used the Readjustment Counseling Program and the contacts they had with vet center staff. However, our assessment of the data base's accuracy indicated that information on the number of clients seen and contacts made was questionable. Moreover, throughout fiscal year 1985, the data base was so incomplete that it was discontinued, in January 1986, and replaced, in October 1986, with a manual system.

To maintain the program's data base, vet center staff were required to submit to VA's data processing center two types of forms for each client they served. The first was a data code sheet that requested information about a client's personal characteristics (such as date of birth and marital status) and military service (such as period and branch of service). This form was to be submitted for every new client seen. The second form was a contact sheet that requested information about the problems affecting the client. It was to be submitted for face-to-face contacts, including the first contact with the client. The code sheet and contact sheet forms remained essentially unchanged from December 1979 until the start of fiscal year 1985. At that time, both forms were expanded to include more detailed information. Clients in the data base are identified by a vet center-assigned number, not by name.

Accuracy of Client Profiles

To assess the data base accuracy of client profiles (including personal and military service characteristics), we compared information in the data base with information in a total of 100 clinical files we sampled (at the 12 vet centers we reviewed); it was not practical for us to review a large enough sample of actual client records at the vet centers to be able to project the nationwide information the Senate Veterans' Affairs Committee Chairman requested. (App. IV discusses the methodology we used to select the sample.) Our results are projectable only to active files at the 12 centers visited. We identified discrepancies between the data base and the code sheet (keypunch errors), as well as discrepancies between the data base and other documents in the clients' files. If there were no documents in a file with which to verify the data base, we assumed it was correct. We compared information on six personal characteristics (sex, date of birth, race, marital status, education, and employment status) and two military service characteristics (period of service and service-connected disability status).

Keypunch errors did not exceed 4 percent for any of the eight characteristics examined. Discrepancies between the data base and other documents in the file did not exceed 3 percent for five of the characteristics. However, our review showed a discrepancy rate of 7 percent for "date of birth," 14 percent for "education," and 16 percent for "service-connected disability status." (The projectability of these results is discussed further in app. IV.) The program director and regional officials indicated they believed that, generally, personal and military service characteristics in the data base were reasonably accurate.

Except for identifying keypunch errors, we did not assess the accuracy of data base information about clients' problems because there was not sufficient documentation in the clients' files. Keypunch errors were less than 1 percent. The assistant regional managers for counseling in regions III and VI said they believed that the accuracy of the data on clients' problems was less than the accuracy of the data on their personal and military characteristics; the assistant regional managers added that accuracy varied depending on the staff that completed the forms. Most of the team leaders we interviewed told us that they did not review contact sheets for clinical accuracy.

Accuracy of Number of Clients and Client Contacts

The results of our questionnaire and our review of sample files and other vet center records indicated that the number of clients and client contacts in the data base is questionable. Vet center staffs did not consistently report contacts; they reported contacts that did not occur or that did not involve assistance to a client. Moreover, the number of clients and client contacts in the data base did not always agree with vet center records. We could not determine whether, overall, the numbers in the data base were overstated, understated, or accurate.

VA's instructions for completing contact sheets required that they be completed each time a vet center staff member had a face-to-face contact with a veteran. The Readjustment Counseling Service director told us he never defined what a face-to-face contact was because he felt it was clear to program staff that only counseling sessions in which emotional problems were seriously discussed should be reported as contacts.

However, in December 1986, after we discussed our findings with him, the director notified the regional managers that contacts with clients should not be reported as visits if they consisted primarily of social conversations, recreational activities, or casual visits. Further, contacts should not be reported if a counselor only wrote a letter, made a phone call, or performed some other administrative activity concerning a client.

The instructions for completing contact sheets further specified that a telephone contact with a veteran could be reported if a major change occurred. In August 1984, the instructions were clarified to require vet center staff to report telephone calls but only those involving counseling, defined as "substantive communication with a client." The instructions specifically excluded telephone calls that were

> "simple greetings in nature, redirecting erroneous requests for assistance, rescheduling/cancelling/ confirming/reminding about scheduled appointments, or any other contact with a client or significant other that is not of a substantive direct services or consultative nature."

The instructions did not explicitly address whether contact sheets should be completed for non-Vietnam era veterans or for veterans with dishonorable discharges. However, the code sheets did request information about clients' periods of service and discharge eligibility, suggesting that such clients and their contacts should have been reported. The Readjustment Counseling Service director said, however, he was not sure if vet center staff should fill out contact sheets for these veterans.

Vet Center Staffs Did Not Consistently Document Client Contacts

The results of our questionnaire indicated that, except for individual and group counseling, vet centers were not consistent in completing contact sheets in fiscal year 1985, as shown in table 4.1.

Table 4.1: Vet Center Documentation of Counseling and Noncounseling Assistance Using Contact Sheets(Fiscal Year 1985)[a]

Situation	Percent of centers regularly documenting assistance[b]
Counseling assistance	
Individual sessions	
Scheduled	99
Unscheduled	92
Group sessions	96
Telephone sessions	64
Sessions with dishonorably discharged Vietnam era veterans	56
Sessions with non-Vietnam era veterans	54
Noncounseling assistance	
Unscheduled visit	58
Making an appointment for a new client	22
Giving information on services	20
Making an appointment for a current client	19

[a] For vet centers that opened before October 1, 1984.

[b] "Regularly" was defined to be at least 75 percent of contacts with veterans in each situation category.

Since we do not know how often each of the above situations occurred, we could not conclude whether the inconsistent reporting overstated or understated the data base.

Staffs at Centers Visited Reported Contacts That Did Not Occur

Thirty-five of the 100 sample files included contact sheets reporting a client visit or telephone session that did not occur or that did not involve providing assistance to the client, for example:

- Fifteen files included contact sheets that indicated a client visit occurred when the progress notes in the client's clinical file stated that a vet center staff member only mailed the client a follow-up letter. In one instance, a client file included four contact sheets. According to notes in the file, the initial contact was made by mail, and the subsequent contacts were follow-up letters.
- Six files, all from the same vet center, included contact sheets that indicated a client visit occurred; the progress notes, however, stated that the veterans only attended a group presentation by vet center staff at the veterans' place of employment. The team leader told us contact sheets were completed because he expected several veterans attending the presentation to come to the center afterwards. To be consistent, he said, a contact sheet was completed for each veteran in attendance. None of

these six clients had come to the center for services as of the time of our visit, over a year after the presentation was made.

- Six files included contact sheets that indicated a client visit occurred when the progress notes stated only that the clients made a casual visit, for example, to pick up a bumper sticker, drink coffee and socialize, or inform the staff of a job opportunity for other veterans.
- Four files included contact sheets that indicated a client visit or telephone session occurred when the progress notes stated only that a telephone contact with a third party was made. In one instance, a veterans' organization representative called a counselor to inform him that a client did not show for an appointment.
- Two files included contact sheets that indicated a client visit occurred when the progress notes stated one client missed his appointment and the other rescheduled an appointment.

Thirty-four percent of the staff members (excluding employment counselors) we interviewed who filled out contact sheets told us they completed contact sheets for casual visits because they (1) were important to the veterans' therapy, (2) may have been a client's way of asking for help, or (3) actually represented services provided. For example, the Las Vegas Vet Center team leader told us that a large percentage of that center's reported contacts were with homeless or transient veterans who used the center to shower, do laundry, read a newspaper, or just "hang out." He considered these as services offered to clients and, to account for all clients coming to the center, he said staff documented nearly all of them on contact sheets. Moreover, during region VI's June 1985 regional training, center staff were instructed to prepare contact sheets for casual visits if the need for socialization, as part of the readjustment process, was documented in the client's treatment plan. Staff members completed contact sheets for clients who attended group recreational activiities, such as softball games, organized by the vet center; we were told this by 16 percent of the staff members (excluding employment counselors) we interviewed who filled out contact sheets; no examples, however, appeared in our sample.

The above examples suggest that client contacts are overstated. However, counselors at three centers told us that they did not always have time to submit contact sheets for reportable contacts. The team leader at a fourth center said one of his counselors often did not complete the forms because he disliked paperwork. Generally, officials at these centers told us they had procedures established to detect unreported contacts.

Statistics in the Data Base Did Not Agree With Vet Center Records

At the 12 centers, we compared (1) the total number of clients seen according to the data base with the number according to vet center records and (2) for our sample files, the number of contacts reported in the data base with the number of contact sheets in the clinical files. The discrepancies we found indicated that the number of clients and contacts is inaccurate in the data base.

The total number of clients seen at the centers visited was about 33,450 according to the centers' records, but about 31,100 according to the data base.[1] At three centers, the number of clients in the data base was more than the number in the centers' records. Officials at two of these centers suggested that some clients may have been assigned two numbers, thus overstating the data base total. (Two files in our sample, though not from these centers, were for clients assigned more than one number.)

At the remaining nine centers, the number of clients in the data base was less than the number in the centers' records. Although a portion of this discrepancy is most likely due to a lag in entering code sheets into the data base, officials also suggested that some code sheets may never have been forwarded to the data processing center; others may have been rejected by the computer program and never reentered.

In the 100 sample files we reviewed, we found a total of 1,353 contact sheets compared with 1,300 in the data base. Although the overall discrepancy was small, 15 of the files had a lesser number of contacts than did the data base, and 23 files had a greater number. The discrepancies ranged from 1 to 76, with about three-quarters of them being 5 or less. Since we did not count contacts in the file that occurred after the date of the last contact in the data base, the time lag in entering contact sheets into the data base should not have accounted for a significant part of the discrepancy. Because of errors in assigning client numbers, we were told that the data base overstated the number of contacts two clients in our sample made. Some of the contacts attributed to these clients in the data base were actually made by clients outside our sample.

Computerized Data Base Discontinued

In August 1984, the Readjustment Counseling Program officials revised both the code and contact sheets to collect more detailed demographic and clinical information about clients and workload statistics about vet center staff. According to the program director, the more detailed data base was to be used as a clinical, management, and research tool. Vet center staff began using the new data collection forms in October 1984.

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[1] For three centers, we increased the data base count to allow us to compare those numbers with the vet center records at the same point in time.

However, throughout fiscal year 1985, Readjustment Counseling Program officials faced numerous delays in making the new system operational because of computer design and programming problems, as well as user confusion over how to complete the new forms. In early 1985, these problems caused the data processing center to return for corrections about 28 percent of the forms it received. According to Readjustment Counseling Program statistics, over 11 percent of client code sheets were never entered into the data base. Moreover, region VI officials told us that in an effort to reduce the number of forms returned for correction, counselors would either not code all clients' problems on contact sheets or would code the problem information exactly as it had been done on the previous sheet.

The Readjustment Counseling Program officials told us they took several steps to try to resolve their problems, including requiring that (1) regional offices instruct center staff on how to complete the code and contact sheets, (2) regional officials in early fiscal year 1986 only visit centers with the most difficulty completing their forms, (3) each center designate a staff member to assure that forms were properly coded, (4) centers with difficulties seek assistance from staff at centers with few problems, and (5) programming changes be considered.

The Readjustment Counseling Program director said that despite these efforts, the new data collection system was still too complex and consumed too much of counselors' time. In January 1986, the system was discontinued. As was the case during fiscal year 1985, the only statistical information regional and central office program managers received about vet center clients, after the system was discontinued, was a periodic report of new clients seen and client visits made, which were counted by a manual system.

In place of the computerized data base, a manual system for data collection was established. This system was implemented on October 1, 1986, and collected what the director considered to be minimum program data needs: the number of new clients seen; whether clients had served during the Vietnam era; the number of client visits made; and staff time spent (1) counseling clients face-to-face inside and outside vet centers, (2) counseling clients on the telephone, (3) traveling to counsel clients, and (4) consulting with, educating, or developing community resources or other services for veterans. The system collected no demographic or clinical data about clients except their problems.

Conclusions

To determine the continued need for centers in particular locations, the Readjustment Counseling Service needs an accurate count of clients who come to vet centers and the number of times those clients receive counseling. However, the data collected since program inception will be of little use to VA for making decisions about the need for specific centers because (1) reportable clients and client contacts were not consistently defined or reported and (2) vet center records did not always agree with the data base statistics.

The new data collection system should provide the Readjustment Counseling Service with the minimum data it needs to manage the program. In addition, the director's December 1986 actions—to clarify which client contacts should be reported—should also increase the reliability of the data. Because of these recent actions, we are not making any recommendations.

Agency Comments

In his June 11 letter, the Administrator said that the data system used from 1980 through 1984 was cumbersome, and the system promulgated in 1985 was even more so. He added that the system begun in fiscal year 1987 is much more streamlined.

Most Vet Center Staffs Met VA Qualifications

Both our questionnaire and site visits indicated that the vet centers were operated by an adequate complement of professional staffs whose qualifications generally met those specified by the Readjustment Counseling Service Program Guide (issued in 1982); that is, staff members were Vietnam era veterans with the appropriate academic degrees and work experience. Moreover, we found that many of the centers were able to augment their professional staffs with volunteers, students (who were veterans) in work-study programs, and graduate students.

However, responses to our questionnaire indicated that about 25 to 50 percent of the team leaders and satellite coordinators hired since October 1, 1984, had not received the training they were supposed to have concerning many areas, for example, the adjustment problems of Vietnam veterans.

Vet Centers Were Staffed in Accordance With Program Guide

The Readjustment Counseling Service Program Guide states that vet centers are to be staffed by four-member or five-member teams (each with a team leader), two or three counselors, and a clerical staff member. (According to the director, qualified clerical staff may have counseling responsibilities.) The Guide also states that satellite centers (discussed in ch. 1) are to be staffed by one to three people. According to the program director, satellite center staff usually are all counselors, including the satellite coordinator. The centers are also encouraged to use volunteers, work-study students, and graduate interns to augment and balance their small permanent staffs.

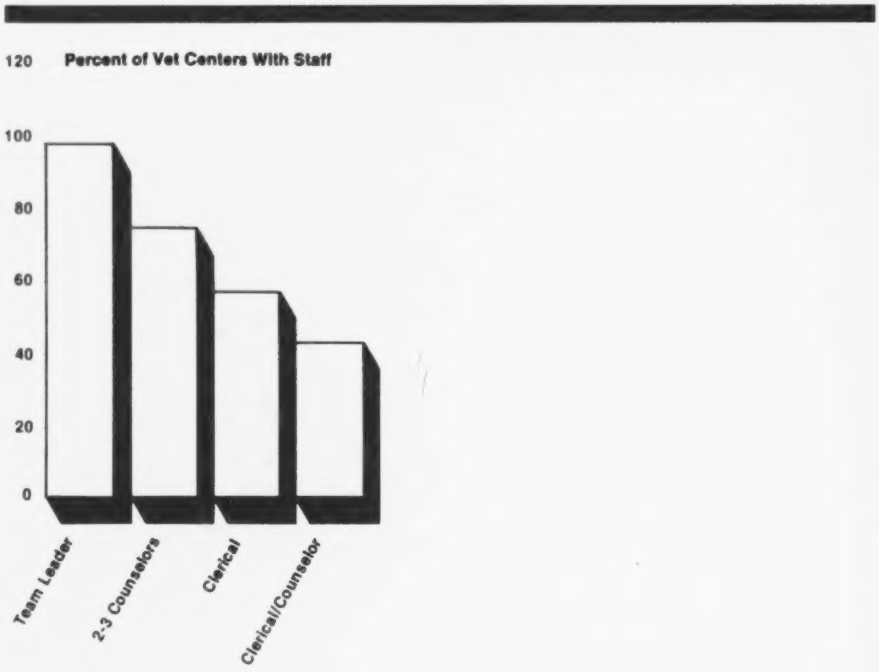
As of early January 1986, vet centers were generally staffed in accordance with the Guide, as shown in figures 5.1 and 5.2.

Staff composition as of early January 1986, at the 12 centers we visited, was generally consistent with the Program Guide. According to the program director, deviations from the Guide are almost always due to unusually high or low client activity.

Vet centers were also able to supplement their staffs, primarily with clerical volunteers or work-study students, as illustrated in figure 5.3.

All 12 vet centers we visited had at least one clerical volunteer or work-study student on the staff at some time between January and May 1986; three centers had volunteer counselors or professionals. For example, a part-time volunteer at the Boston Vet Center was an attorney who provided discharge upgrade assistance. Additionally, three centers used

Figure 5.1: Staff Composition at Vet Centers (Jan. 1986)



other types of volunteers, including one who helped write a center newsletter and another who provided academic tutoring to clients.

Three of the centers we visited had graduate student interns on their staffs in early January 1986, and a fourth center had one at the time of our visit in May 1986. Other centers did not use interns for these reasons: (1) they were not available or willing to work at the center, and (2) the center had no funds for them or no time or staff to adequately supervise them.

In addition to VA-salaried and volunteer staff, vet centers also had others on hand to provide services to clients in fiscal year 1985. According to the questionnaire results, 79 percent of centers that opened before October 1, 1984, had a Disabled Veterans' Outreach Program specialist[1] provide employment services to veterans. About half of the centers that

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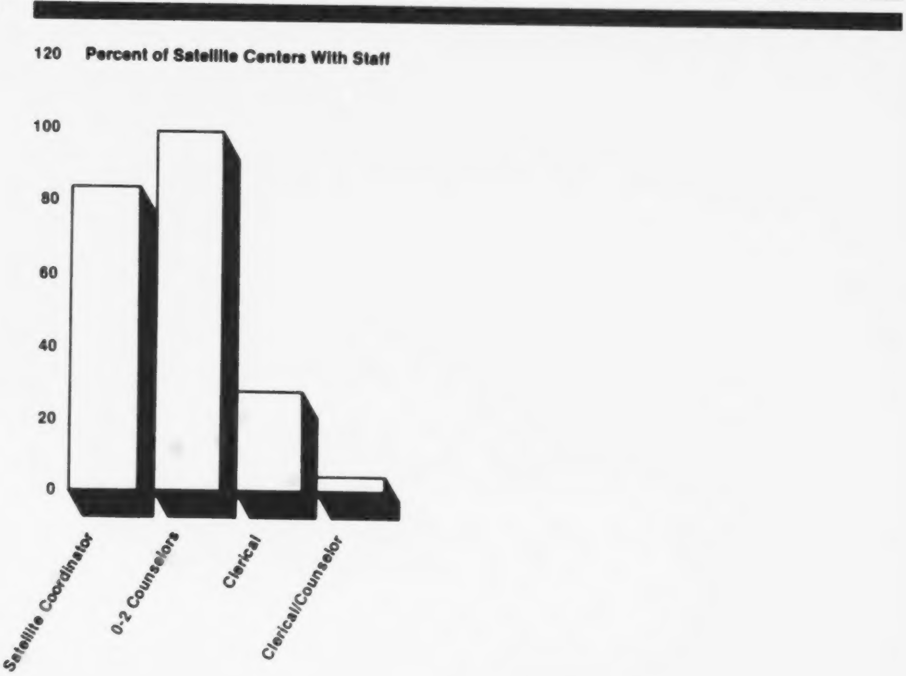
[1] The Disabled Veterans' Outreach Program, established by the Veterans' Rehabilitation and Education Amendments of 1980 (Public Law 96-466), was designed to meet the employment needs of veterans, particularly disabled Vietnam era veterans, by providing funds to states to, among other things, develop job and job-training opportunities for them.

Figure 5.2: Staff Composition at Satellite Centers (Jan. 1986)

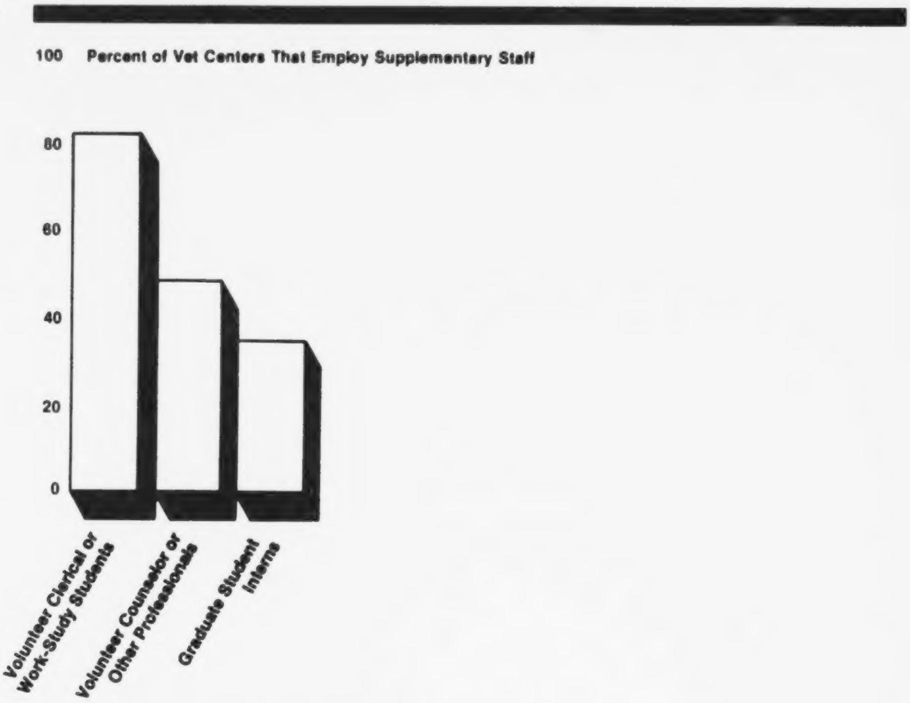


opened before October 1, 1984, also used other VA and veterans' organization staffs to provide services. At the St. Petersburg Vet Center, for example, the team leader told us that the PTSD unit coordinator and a psychiatric nurse from the support facility led a group for clients' wives and girlfriends and provided family counseling. The Bangor Vet Center team leader told us a staff psychologist from the support facility came there 3 days a month to evaluate clients. At five centers we visited, representatives from veterans' organizations provided clients assistance, such as helping them process their disability claims.

Most Vet Center Staffs Had Relevant Experience

A Readjustment Counseling Program circular provides examples of academic background and work experience considered relevant to center counseling functions (including possession of a clinically oriented degree in a field such as psychology, social work, or counseling and experience in readjustment, crisis and emergency, or community-based counseling). The circular also notes that experience in management, supervision, and media relations is relevant for team leaders and suggests that team leaders and counselors be Vietnam theater, or at least Vietnam era, veterans.

Figure 5.3: Availability of Supplementary Staff at Vet Centers[a] (Jan. 1986)



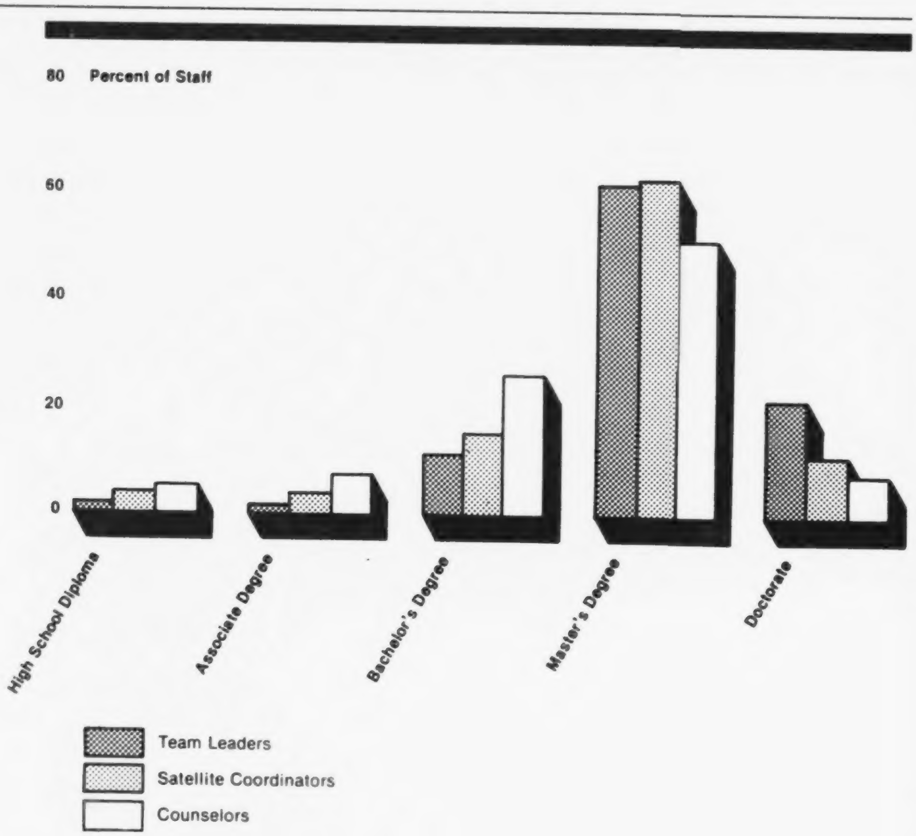
[a] For vet centers that opened before fiscal year 1975.

Most vet center staff met the program's academic background expectations, as indicated in figures 5.4. and 5.5.

Team leaders at the centers we visited had comparable academic degrees, but proportionally fewer counselors had studied in a professionally related field.

Team leaders reported in the questionnaire that half of them had over 8 years of professional experience in counseling, mental health, social work, or other social service employment; 85 percent of them had over 4 years of experience. Seventy-seven percent of satellite coordinators and 60 percent of the counselors had more than 4 years of such experience. This was generally comparable with the experience the staffs at the centers we visited told us that they had. The team leader at the Jackson Vet

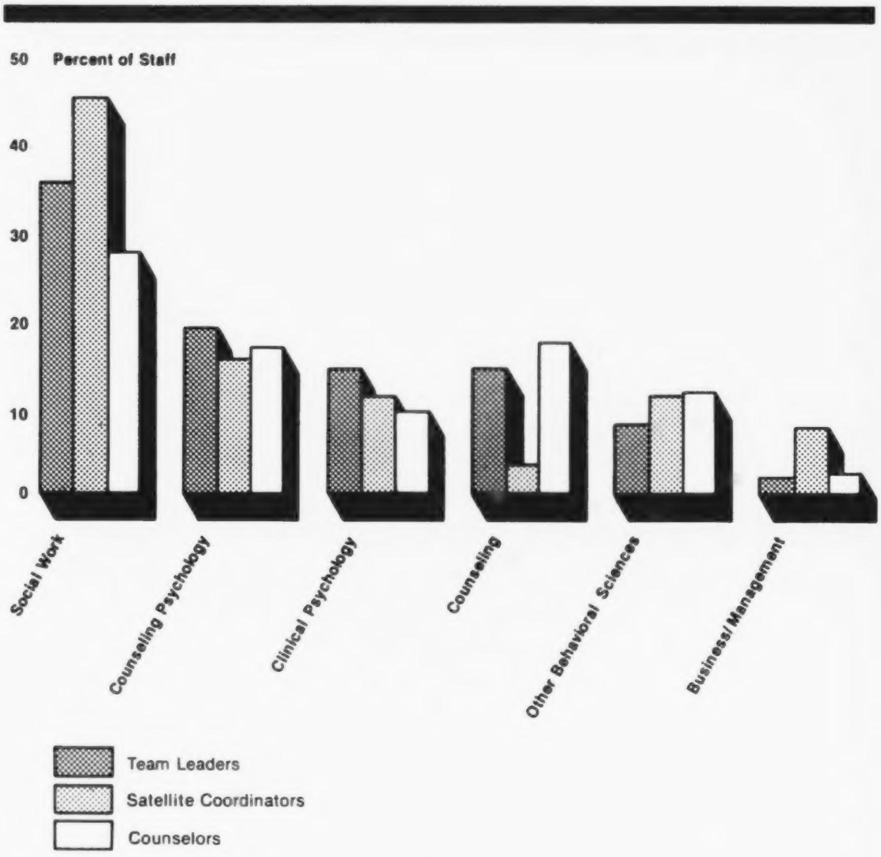
Figure 5.4: Highest Academic Degree Earned by Team Leaders, Satellite Coordinators, and Counselors (1986)



Center, for example, had a background as director of a community alcohol and drug treatment program, supervisor in a state vocational rehabilitation office, and teacher of various subjects relating to human relations and substance abuse. At least two-thirds of the team leaders we talked with also had prior experience in supervision and media relations.

For the most part, vet center staffs were Vietnam era veterans, as shown in figure 5.6.

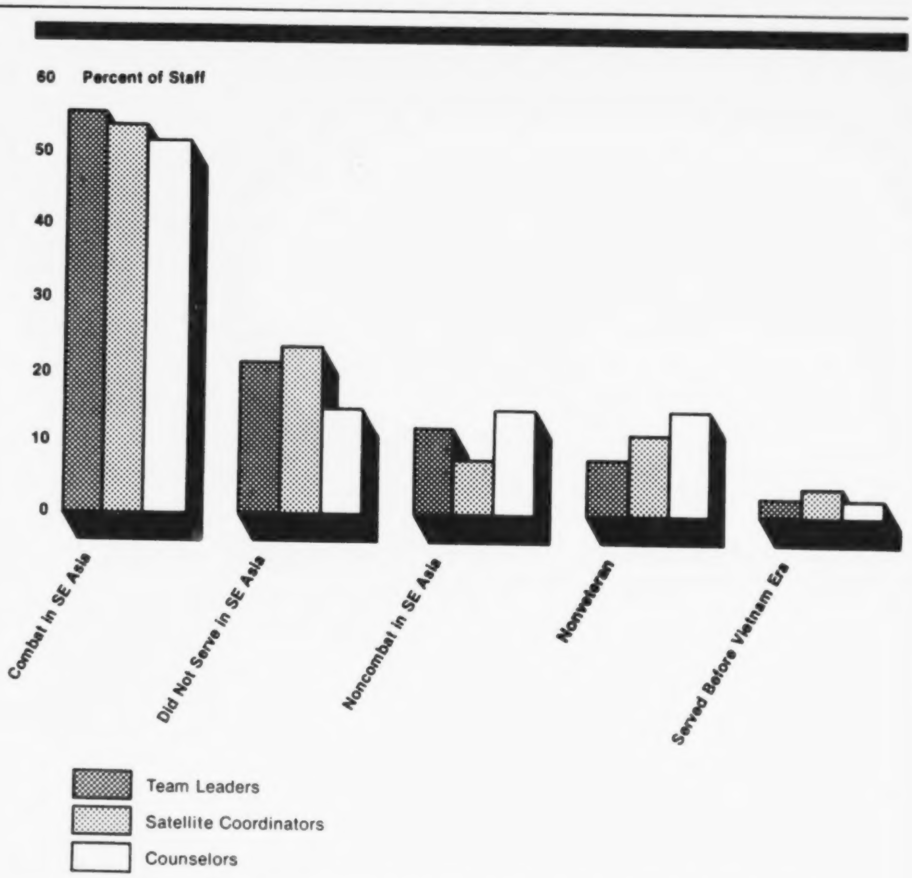
Figure 5.5: Primary Academic Field of Study of Team Leaders, Satellite Coordinators, and Counselors (1986)



Most Vet Center Staffs Included a Recognized VA Mental Health Professional

The original program legislation authorized VA to use paraprofessionals on the vet center staffs. In explaining this provision, the Senate Committee on Veterans' Affairs stated that much of the initial intake and screening could be most effectively provided by trained paraprofessionals; as they gained experience, these paraprofessionals would become sensitive to the readjustment needs and problems of veterans. The report further stated that the vast majority of cases should not require extensive use of highly trained psychiatric and psychological personnel. However, in May 1984, the Senate Committee noted that there appeared to be a need for additional mental health professionals in the vet centers. The Committee was concerned that the veterans needed more

Figure 5.6: Veteran Status of Team Leaders, Satellite Coordinators, and Counselors (1986)



extensive mental health services than the "relatively brief and superficial supportive counseling, with referrals for more definitive treatment," that were being provided.

To improve the quality of care, the Readjustment Counseling Service director established a policy in 1982, he told us, requiring each center to have a qualified mental health professional. A qualified mental health professional is defined by the service as any one of the following:

- a psychiatrist who has completed 3 years of psychiatric residency,
- a clinical or counseling psychologist with a doctorate who has attended an American Psychological Association-approved school and completed an association-approved internship,
- a social worker who has a master's degree in social work from a school accredited by the Council on Social Work Education, or

- a psychiatric nurse clinical specialist who has a master of arts in psychiatric nursing with associated training.

The director said that one mental health professional was included in the hiring plan of each new center; the position was being added at existing centers as other staff left the program. As of March 1987, 84 percent of the centers nationwide included a mental health professional for each center.

Many Staff Were in Their Positions Less Than 1 Year

Twenty-four percent of team leaders, 55 percent of satellite coordinators, and 23 percent of counselors at centers that opened before October 1, 1984, had been in their positions less than 1 year at the time the questionnaire was completed. Moreover, during fiscal year 1985, according to the regions' quarterly reports submitted to VA's central office, 29 of these centers had a team leader vacancy; 57 centers had one or more counselor vacancies. The program director stated that many staff members had transferred to the new centers opened that year. He also noted that some staff members left the program because their jobs were emotional and stressful. They had used the centers as stepping-stones in their careers and knew the program's authorization would be expiring.

Staff turnover also occurred in the regional offices and the central office in fiscal year 1985. At the regions we visited, one of three regional managers, two of four associate regional managers for counseling, and one of three associate regional managers for administration left their positions during this time. At the central office, the assistant director for counseling and the assistant director for administration left the program.

Regional Offices Provided Most of the Required Training to Vet Center Staffs

In their management objectives for fiscal year 1985, regional staffs were required to provide two training sessions—one for team leaders and one for team leaders together with other vet center staffs.[2] The management objectives did not specify the content of the sessions. The director stated that he saw no need to prescribe course content because, since the program's inception, courses were continually being developed. He told us that the central office monitored the provision of training by reviewing the training agendas.

The three regions we visited conducted the required training in fiscal year 1985. Sessions for team leaders covered issues such as fiscal and personnel matters and clinical recordkeeping. The sessions for all staff members included counseling for special populations, domestic violence, and substance abuse; clinical writing; treating PTSD; and psychotherapy methods. All regions visited developed their training agendas based on a needs assessment. Region I officials told us, for example, they formed curriculum committees prior to each course to help develop the agenda.

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[2] Region II training was required only for team leaders.

Most vet center staffs received training in fiscal year 1985 in the areas listed in table 5.1. Usually, this training was provided by the program's regional staff.

Table 5.1: Training Provided to Vet Center Staffs[a] (Fiscal Year 1985)

Area	Percent of vet centers receiving training
PTSD treatment	95
Individual counseling techniques	92
Group counseling techniques	91
Administration/management techniques	90
Stress reduction management	89
Treatment of substance abusers	88
Family counseling techniques	86
Treatment of clinical disorders	86
Marriage counseling techniques	78

[a] For vet centers that opened before October 1, 1984.

Not All New Team Leaders and Satellite Coordinators Received Orientation Training

To introduce new staff (particularly those hired at the 52 centers that opened beginning in fiscal year 1985) to the Readjustment Counseling Program, the regional offices were required to develop special orientation sessions. However, about one-quarter to one-half of the team leaders and satellite coordinators hired since October 1, 1984, reported that they did not receive training in many areas. The director considered all the areas listed in table 5.2 to be valid ones for orientation training.

Table 5.2: Orientation Training Given to Team Leaders and Satellite Coordinators
(Fiscal Year 1985)[a]

	Percent receiving training	
Area	**Team leaders**	**Satellite coordinators**
Vietnam veterans' adjustment problems	72	68
Diagnosis and treatment of PTSD	68	58
Administrative/fiscal requirements	64	63
VA administrative and support services	64	74
Clinical recordkeeping	64	63
Needs of special groups (e.g., minority and disabled)	63	63
Vet center outreach techniques	63	53
Crisis intervention	61	63
Individual and group counseling techniques	60	63
Community relations	55	37
Working with media	48	42
History of Vietnam and Vietnam war	48	63
Staff development	44	42
VA benefits and discharge upgrade process	41	63

[a] Including only team leaders and satellite coordinators that were hired after October 1, 1984.

The director could not explain why many new team leaders and satellite coordinators reported that they did not receive orientation training. He noted that training held jointly by regions V and VI was not well organized. Thirteen of the 22 team leaders and satellite coordinators who reported they received no training were from these two regions. The director said he intended to further investigate attendance at orientation training.

According to regions III and VI officials, to help orient staffs at newly established centers, these officials paired new staff members with staff members at a nearby established center. For example, in region VI the new center staff spent time at their assigned center for on-the-job training and then were encouraged to rely on that center to answer questions as they arose.

Conclusions

Vet center staffs generally had the qualifications intended by the program guidance. However, about one-quarter to one-half of new team leaders and satellite coordinators reported that they had not received orientation training in many relevant areas. Program expansion is now complete, but staff turnover makes continued training of new staff necessary. If the director monitors the provision of orientation training, as he indicated he would, this should assure that new staff are introduced to program requirements and issues.

Agency Comments

In his June 11 letter, the Administrator said that VA believed that in responding to our questionnaire, recently hired team leaders and satellite coordinators under-reported the training they received. Nonetheless, he stated that our findings were "cause for concern." He added that regional management staff have been instructed to assure that newly hired staff uniformly obtain training in the areas specified in table 5.2.

Chapter 6

Outreach, Service Provision, and Referral Systems Well Established, but Follow-Up Not Always Emphasized

The Readjustment Counseling Service Program Guide, issued in 1982, states that each vet center should develop a systematic outreach program, a program of readjustment counseling services, and an appropriate community-based referral network. Each center should also conduct timely follow-up to counseling and referral services provided. For outreach, the vet centers used a variety of techniques to identify and locate Vietnam veterans who could benefit from the program, and offered an array of services to them. The centers also had well-established referral networks. However, officials at nine of the centers acknowledged that their follow-up of clients was often not done or was dependent on the judgment of individual counselors.

Centers Used a Variety of Outreach Techniques

According to the Readjustment Counseling Service Program Guide, outreach is an essential aspect of vet center functions. The Guide defines outreach as any activity by which vet centers locate, identify, or otherwise come into contact with Vietnam veterans who may need readjustment counseling services.

According to the questionnaire responses, the most popular outreach techniques were developing relations with other service agencies and sponsoring community education programs. Officials from all the centers we visited told us that they conducted outreach by developing relations with other service agencies; officials from 11 centers told us that they sponsored community education programs. The Bangor Vet Center, for example, made quarterly presentations to a regional council on alcohol and drug abuse in order to educate and inform the council about the vet center and veterans' readjustment problems. The St. Petersburg Vet Center held an open house for veterans and local community and VA officials.

Forty-two percent of the centers nationwide reported in the questionnaire that they frequently used television, newspapers, and other media as an outreach technique. All but one center we visited used this technique. For example, the Las Vegas Vet Center team leader said that he had a local television station flash the center's name and phone number on the screen periodically during programs on Vietnam. Knoxville Vet Center team members participated in radio and television talk and news shows on veterans and vet center activities.

Less frequently used outreach techniques, according to the questionnaire responses, were direct mailings, pamphlets or newsletters, notices in public places, and special advertising items. With the exception of special advertising items, less than half the centers we visited used these outreach techniques. For example, only four centers periodically published a newsletter. The Oakland Vet Center team leader said that direct mailings were not effective because many veterans in that area were homeless or transient, and would not be reached. Although not popular nationwide, six centers visited used special advertising items, such as bumper stickers, to advertise their services.

In addition to the outreach techniques mentioned in responses to the questionnaire, some centers we visited used other techniques. For example, the Greenville (South Carolina) Vet Center clients, wearing hats with the vet center name on them, parked cars and greeted people attending a local festival. The Bangor Vet Center periodically set up a booth at a shopping mall; the team leader stated that this was an effective way to reach prospective clients.

Centers Offered an Array of Services

Program guidance states that vet centers should provide individual and group counseling and a program involving family members and significant others in counseling. The Readjustment Counseling Service director stated that all centers should also provide these services: a 24-hour telephone service so that center staff can be available to clients in need at any time, group counseling specifically for minorities and women if the population is sufficient to justify it, and employment and vocational assistance because chronic unemployment is a symptom of readjustment problems.

Most centers offered a wide array of services, as shown in table 6.1.

Table 6.1: Services Offered by Vet Centers[a] (Jan. 1986)

Service	Percent of centers offering service
Individual counseling for veterans	100
Individual counseling for veterans' spouses/significant others	99
Group counseling for veterans	99
Family counseling	98
Marriage counseling	98
Employment/vocational assistance	92
Substance abuse counseling	91
Group counseling for veterans' spouses/ significant others	86
Individual counseling for children of veterans	81
VA benefits assistance	81
General welfare assistance	72
Counseling or services specifically for minorities	71
Counseling or services specifically for women	67
Discharge upgrade assistance	62
24-hour telephone crisis intervention/ telephone-answering service	61

[a] For vet centers that opened before October 1, 1984.

Services provided by the centers we visited were generally consistent with the questionnaire responses, except that proportionally fewer centers (the percentage of centers we visited compared with the percentage of the total centers responding to the questionnaire) provided group counseling for spouses and significant others, services specifically for minorities and women, and discharge upgrade assistance. Vet center staffs told us that, generally, the services clients used most frequently were individual and group counseling for veterans and employment assistance. Staff members gave a variety of reasons why other services were not used as frequently, for example:

- A San Jose Vet Center counselor noted that family counseling was not popular because many veterans in that area had no family, and others were reluctant to involve their families in their therapy.
- Officials at seven centers said children were not counseled frequently because the teams lacked expertise or time, relied on referral agencies, or simply did not see enough children needing counseling.
- The Las Vegas Vet Center team leader stated that his center had no interest in a spouse or significant other counseling group because participation in previous groups was low.

- Officials at three vet centers told us that they usually referred clients needing general welfare assistance to other agencies.

Group Activities at Vet Centers Visited

The 12 centers we visited offered an average of four counseling groups. The number ranged from one at the Jackson and Las Vegas Vet Centers to eight at the Albuquerque Vet Center. At 10 of these centers we observed a total of 14 groups, as shown in table 6.2.

Table 6.2: Counseling Groups Observed

Type of group	Number of groups observed	Average number of participants
General counseling for veterans	9	7
Counseling for spouses and significant others	2	6
Alcohol awareness	2	11
Anger management	1	6

No group sessions were held at the remaining two centers during our visit.

In addition to groups held at vet centers, we were told that staff at the Albuquerque Vet Center conducted sessions for psychiatric patients at its support facility, and staff at the St. Petersburg Vet Center, sessions for PTSD patients at its support facility. Additionally, the Pawtucket (Rhode Island) Vet Center staff conducted a group for veterans at a community mental health clinic.

Eight centers also conducted group activities such as softball games, parties, and field trips. The Greenville Vet Center, for example, organized a weekend camping trip for clients and their families. A counselor at the Albuquerque Vet Center told us that someone from the support facility led a poetry group for vet center clients. Staff at several vet centers told us that they considered these activities therapeutic and helpful to clients in developing their social skills.

Not All Services Were Provided in a Counseling Context

The primary mission of the Readjustment Counseling Program is to provide needed readjustment counseling. In a description of the services vet center staff are expected to provide, the Readjustment Counseling Service director stated that technical assistance—(1) helping veterans prepare benefits claims, find a job, or upgrade their military discharge or (2) testing veterans for educational level or vocational skills—was not appropriate unless such assistance was incidental to the general counseling process. If the technical assistance needed was an integral part of the veteran's readjustment process, the director stated, and if the counselor had the appropriate technical skills, this assistance could properly be provided and could be very helpful. This position was arrived at by VA based on congressional hearings, committee reports, and prior experience by mental health professionals and community-based Vietnam veteran service organizations in the private sector.

As noted earlier, the questionnaire responses indicated that the majority of vet centers offered technical assistance. Our review of 100 clinical files suggested, however, that such assistance was not always provided in a general counseling context. In 16 percent of the cases we reviewed, vet center staff members provided or referred clients for employment and other technical assistance, without documenting that general readjustment counseling was provided, for example:

- A Greenville Vet Center staff member assisted a client who wished to reenter the armed services and needed a copy of his military records. No counseling was documented nor was an assessment of the client's background, military experience, or present situation provided in the progress notes.
- The Pawtucket Vet Center assisted four clients with employment, vocational training, benefits, and a request for records without documenting, in progress notes, that an assessment was made or readjustment counseling was provided. In three of these cases the client was referred to a local veterans' organization.
- A counselor at the Albuquerque Vet Center assessed a client interested in benefits information as functioning well with a positive family relationship and no major problems. The counselor scheduled the client for a VA medical examination, but did not document in progress notes that counseling occurred.

The VA Health Care Amendments of 1985 (Public Law 99-166, Dec. 3, 1985) require VA to establish a pilot program under which designated vet centers provide Vietnam veterans with additional services, including assistance in applying for VA benefits and obtaining jobs. According to the Readjustment Counseling Service director, as of December 1986, two centers were operating under the pilot program. He said technical assistance without readjustment counseling may properly be provided at these centers.

Centers' Referral Networks Well Established

Program guidance notes that the ability to make appropriate referrals is critical to the quality and effectiveness of readjustment counseling. It suggests that vet centers develop an appropriate community-based referral network, including VA sources and other organizations dealing with employment, incarcerated veterans, discharge upgrades, and general welfare. We found that the centers' referral networks were well established and widely used.

Vet Centers Were Aware of Community Services Available for Client Referrals

Nearly all vet centers were aware of a wide variety of services available for referral in their local areas, as shown in table 6.3.

Table 6.3: Services Available to Vet Centers Through Referrals to Other Programs (Fiscal Year 1985)

Service	Percent of vet centers aware of referral service
Substance abuse assistance	98
VA benefits assistance	98
Psychiatric treatment	98
General welfare assistance	98
Employment/vocational assistance	97
Medical assistance	96
Educational assistance	96
Domestic abuse assistance	92
Psychological evaluation	92
Discharge upgrade assistance	90
Legal assistance	80

Nearly all centers with these services available in their communities referred clients to the organizations providing them in fiscal year 1985.

VA facilities (other than vet centers) were most frequently identified as referral targets for clients' VA benefits and substance abuse, as well as psychological, psychiatric, medical, and educational assistance needs. Social service agencies were most frequently identified as referral targets for clients' general welfare and domestic abuse assistance needs; legal aid agencies were most frequently identified as providing legal assistance; employment agencies were most frequently identified as providing employment assistance. Veterans' organizations were most frequently identified as providing discharge upgrade assistance.

The vet centers we visited also had extensive referral networks. Team leaders noted, however, needs that could not be met through the centers' existing networks. The most frequently mentioned were services for homeless and transient veterans. Team leaders from six vet centers indicated that in their areas, there were few shelters to handle these veterans, especially on a long-term basis. Other unmet needs team leaders noted included employment, training, and medical health care for veterans with nonservice-connected disabilities.

We called from six to nine community agencies in the local areas served by each vet center visited; some agencies were identified for us by vet center staff, and we randomly selected others from telephone books. The randomly selected agencies routinely served Vietnam era veterans or their families. Of the total 89 agencies called, 83 percent said that they were familiar with vet center activities. More than half (53 percent) said that they had received referrals from a vet center in the past 6 months; all these agencies said that they believed they were able to assist the veterans referred.

Vet Centers Received Referrals From a Variety of Community Agencies

According to the questionnaire, nearly all centers received referrals in fiscal year 1985 from veteran service organizations, other VA facilities, employment services, mental health providers, substance abuse programs, social service agencies, and the judicial systems. The team leaders we interviewed generally regarded their centers as able to provide relevant services to those referred; according to the team leaders, they received few inappropriate referrals.

Sixty-three percent of the community agencies we called had referred an individual to a center at least once in the previous 6 months. No agency expressed dissatisfaction with the services the vet centers provided. Several complimented vet center staffs for their devotion and assistance to needy veterans.

Most vet centers we visited were attempting to further develop their referral networks. Team leaders at six centers told us that they or their staff had participated in forum activities at local mental health or social service agencies; five team leaders told us that they had mailed informational letters to heads of community agencies.

Follow-Up Not Emphasized

A 1981 review of the Readjustment Counseling Program, conducted by VA's Office of Program Planning and Evaluation, recommended that vet center staff closely monitor the status and progress of all clients, including those referred elsewhere. The review noted that although most centers followed up in some way on clients served directly by the team, the process was rarely systematic and continuous; many centers depended on individual counselors to determine when and if follow-up should be done. The review concluded that such an approach could lead to a high degree of variability in the methods, frequency, and intensity of the follow-up. The office indicated that follow-up was important because it was an expression of commitment and concern and because it would involve an "assessment of the effectiveness and expediency of service provided" by the vet center team.

In December 1981, a DM&S circular required vet centers to follow up on at least 50 percent of their clients within 90 days of their last visit. Further, the 1982 Program Guide states that as a counseling objective, vet center staff should establish a system for conducting timely follow-up. Since December 1984, the standard protocols used by Readjustment Counseling Service regional officials when making clinical site visits to their vet centers required them to assess follow-up procedures.

Since other VA programs, such as mental health clinics, do not require follow-up, according to the Readjustment Counseling Service director, it should not be required for vet centers; compliance with the 50-percent follow-up requirement was never enforced and was no longer valid. Follow-up is important, he said, and should be done, but should not take priority over providing services to current clients.

Regional officials' opinions concerning the importance of follow-up were not consistent. In June 1985, the region VI assistant regional manager for counseling instructed that region's team leaders that follow-up was a clinical exercise, not an administrative task; it was to be conducted by counselors and all cases must either be closed or the client contacted, preferably as early as 1 month after the client's last visit. Similarly, region III officials told us that they expected vet center counselors to either follow up on all clients involved in treatment or, possibly, close out cases of clients seen only once for noncounseling assistance. The region I assistant regional manager for counseling, however, told us that centers in that region were "encouraged," but not required, to follow up on clients.

Officials at nine centers visited said that their follow-up efforts were often not done or were dependent on the judgment of individual counselors, for example:

- Although their clerical staff daily identified clients not seen within the previous 30 days, the Las Vegas Vet Center team leader told us, counselors would usually not follow up on these clients. He said follow-up efforts were not made because the clients did not need further assistance or they were homeless or transient and not reachable.
- Follow-up was a low priority, the Greenville and Springfield Vet Center team leaders told us, because of other demands on staff time. The Greenville Vet Center team leader added that the center's newsletter was mailed to clients and served as a follow-up mechanism.
- Bangor Vet Center officials told us that they relied on work-study students to help conduct follow-up. But since the center had no students for about 6 months in 1985, follow-up was not done.
- Team leaders from the Oakland, St. Petersburg, Knoxville, and Boston Vet Centers relied on individual counselors' deciding if follow-up would be done. Only about 20 percent of clients not seen in the previous 90 days were followed up, according to the Oakland Vet Center team leader, because counselors believed those clients needed no further assistance, were being helped elsewhere, or were homeless or transient and not reachable.

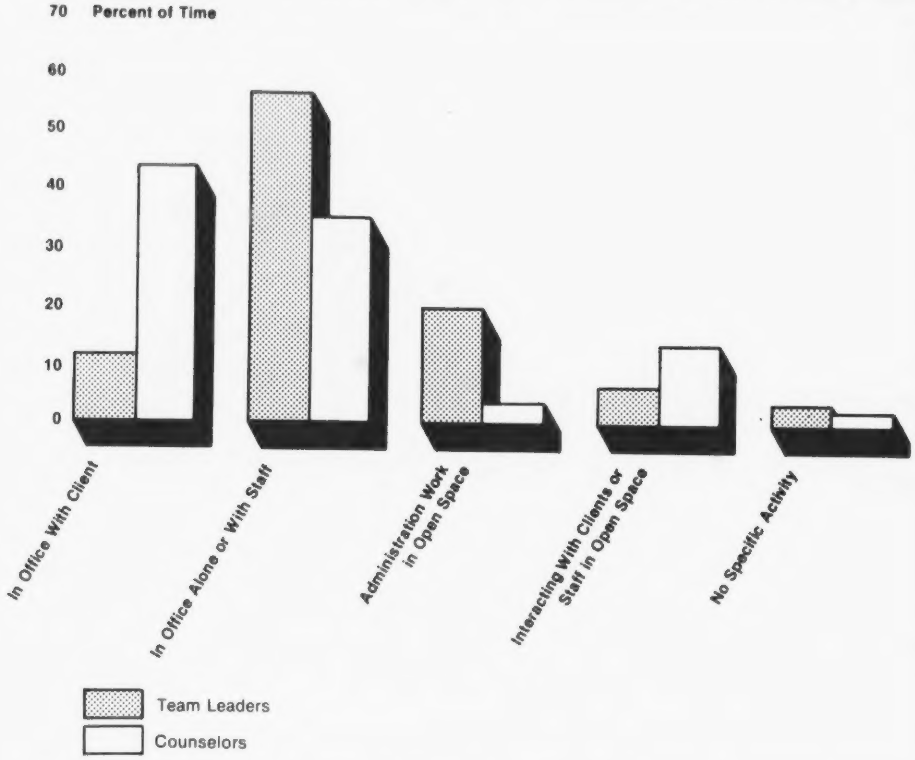
Our Observations of Vet Center Activity

Our daylong, unannounced visits to six vet centers generally occurred from 8:30 a.m. to 5:30 p.m; we did not stay for evening activities. We observed the following about client activity:

- Between 5 and 17 clients came to each center; the average was 9.
- Client visits lasted from 1 minute to over 4 1/2 hours, with the average being about 1 hour.
- On average, clients spent 70 percent of their time with a counselor or other staff member and 30 percent of their time on other activities, such as casual interactions with the staff, reading, using recreational equipment, or walking around the center. Staffs at the vet centers documented 83 nonpersonal telephone calls during our visits. Fifty-five percent of the calls were from Vietnam era veterans, almost half of whom called to schedule an appointment; counseling was provided for 15 percent of the calls. The staff spent an average of 9 minutes on each telephone call.

The number of team leaders and counselors present during our visits ranged from one to four. Office managers were present at all but one center; that center, however, had a volunteer clerical staff member present. Disabled Veterans Outreach Program specialists were present at two centers. Team leaders were at the vet centers an average of 8 hours and 15 minutes, and counselors were at the centers an average of nearly 5 hours and 45 minutes. They spent their time as shown in figure 6.1.

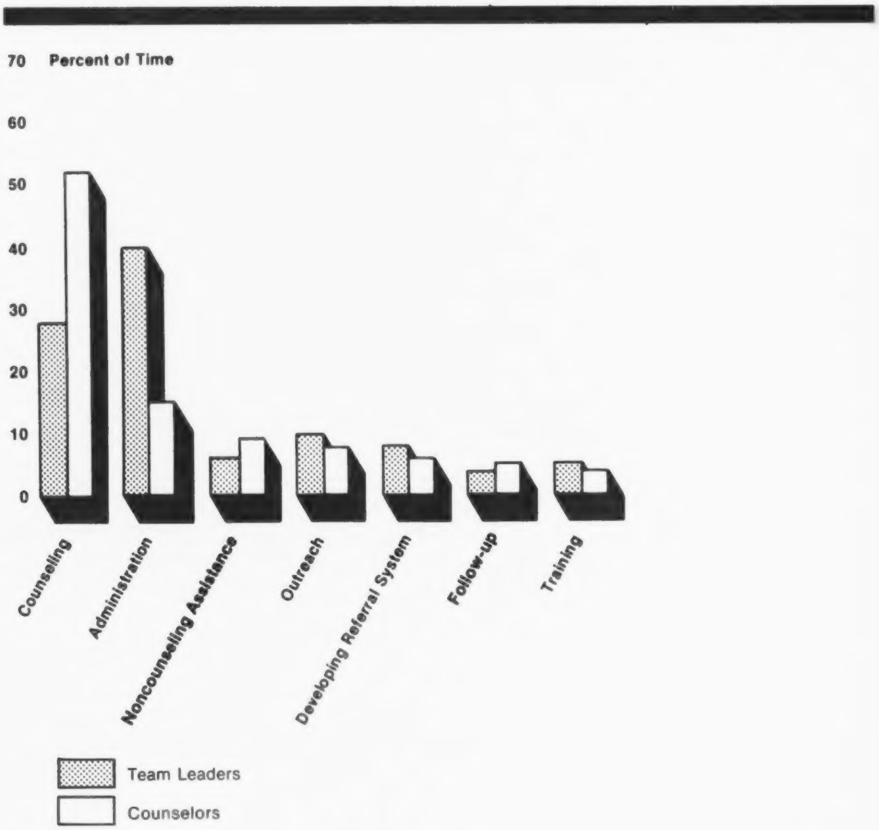
Figure 6.1: Team Leader and Counselor Activities Observed by GAO During Unannounced Site Visits (1986)[a]



[a] A team leader was not present at one of the six vet centers we visited. Thus, the statistics on team leaders are based on observations of only five leaders. The time spent by individual team leaders and counselors on each of these activities varied widely.

The results of our questionnaire, shown in figure 6.2, indicate that vet center staff spent more time counseling clients than our observations indicated.

Figure 6.2: Tasks Performed by Team Leaders and Counselors (1986)



Team leaders reported in the questionnaire that they spent 24 percent of their time away from the vet centers; counselors spent about 19 percent of their time away. Staff members at some of the centers visited told us that this time was spent on activities such as developing relations with other agencies, making presentations, visiting veterans at local jails or their homes, taking training, and attending meetings at support facilities.

Conclusions

Vet centers' outreach, service provision, and referral systems were conducted as specified in the Program Guide. In addition, some centers visited devised their own techniques for reaching and serving clients, although not all services were provided in a counseling context. The centers visited appeared to be well known by community agencies in their areas.

Follow-up of clients was not always conducted. The Readjustment Counseling Service director said, however, that it need not be a high priority. If VA believes follow-up is not important, program guidance should be changed to reflect this. If VA does consider follow-up important, it should better enforce the current requirement.

Recommendations to the Administrator of Veterans Affairs

We recommend that the Administrator direct the chief medical director to (1) clarify the importance of client follow-up, and (2) if follow-up is considered important, monitor regional officials' site visit reports to determine whether follow-up has been adequately conducted.

Agency Comments

In his June 11 letter, the Administrator concurred and stated that by the end of fiscal year 1987, VA plans to distribute revised guidance concerning follow-up requirements. By the same target date, regional management officials' site visit reports will reflect an assessment and evaluation of follow-up activities.

Chapter 7

VA Needs to Increase Collaboration Between Vet Centers and Other VA Facilities

Vet centers are required to maintain administrative relations with their support facilities and collaborate with them in such professional areas as clinical and training matters. We found that there was satisfactory collaboration on administrative and clinical matters; however, for clinical matters and training activities between vet centers and distant support facilities, there was not full collaboration.

In addition, vet centers were not using the specialized PTSD inpatient units in VA hospitals, although the Veterans' Health Care Act of 1984 requires that these units coordinate their services with the Readjustment Counseling Program. According to responses to our questionnaire, 75 percent of the clients identified by vet centers as needing inpatient treatment for PTSD were not referred to a designated unit. Moreover, once a center referred a client to a unit, there was limited contact between the two facilities.

Vet Center and Support Facility Relations Generally Satisfactory

A DM&S program circular and other program guidance state that each vet center and its support facility should maintain administrative relations and collaborate on clinical matters and training. We found, from our visits to 12 centers and the responses to our questionnaire, that the centers were doing this, except, generally, for those centers located 80 or more miles from their support facilities.

Vet center team leaders and support facility liaison officers coordinate this relationship. Most of the liaison officers at the support facilities visited were either chiefs of Psychology or chiefs of Social Work. At two facilities, the liaison officer was an assistant to the medical center director. Generally, liaison officers viewed their responsibilities as assuring that relations between their vet centers and support facilities ran smoothly. In most cases, liaison officers did not expect the vet center staffs to deal directly with them concerning specific issues.

All Vet Centers Collaborated on Administrative Matters With Their Support Facilities

All vet centers that opened before October 1, 1984, reported in the questionnaire that in fiscal year 1985, they met with staff from their support facilities to discuss administrative matters. Officials from the centers and support facilities we visited also told us that they met with one another to discuss administrative matters, for example:

- Five team leaders told us that, in addition to other administrative contact with support facility staff, they participated in their support facility director's monthly staff meetings.
- The Springfield Vet Center team leader told us that the support facility liaison officer participated in that center's monthly staff meetings.
- Officials from the Knoxville Vet Center's support facility said that they met informally with center staff once a month.
- The Bangor and San Jose Vet Centers' team leaders said that they met with support facility staff only as needed.

Most Vet Center and Support Facility Staffs Met to Discuss Clinical Issues

Readjustment Counseling Service policy requires centers to have regular and systematic clinical collaboration, such as attending mental health clinic case conferences, with their support facilities. The director stated that collaboration was necessary to assure that program staff provided quality care. Many vet centers needed clinical assistance, he said; since program regional staff could not conduct frequent site visits (see ch. 8), the best way to get assistance was through contact with support facility personnel. Similarly, support facility staff could learn more from vet centers about how to treat Vietnam veterans.

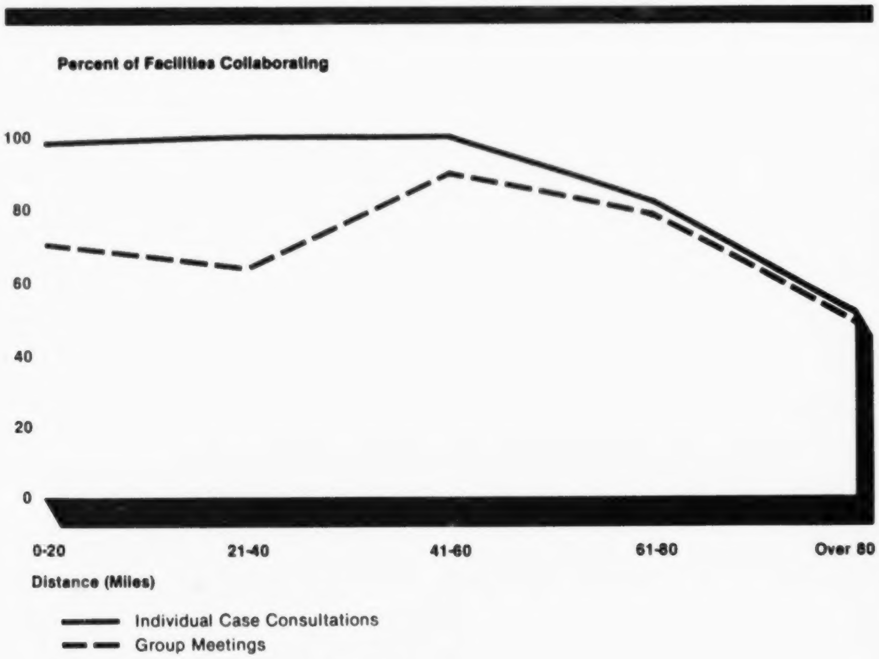
The policy states that although weekly contact is desired, if distance is a problem, the contacts should be made as often as feasible (biweekly or monthly). The contacts must be substantive and, preferably, involve more than one member of the vet center staff. Finally, support facility staff involved should be mental health professionals with significant clinical responsibilities for treating Vietnam veterans or handling referrals between a vet center and support facility or both. The director told us that he expects the contacts to be face-to-face.

In general, we found that, except at facilities 80 or more miles apart, vet center staff met with support facility staff to discuss clinical issues, as shown in figure 7.1.

According to officials at 7 of the 12 vet centers and their support facilities, the officials spoke with one another about clinical matters at least once a week, for example:

- The chief of psychology at the Albuquerque Vet Center's support facility visited weekly, the team leader told us, to discuss specific clients with individual vet center counselors.
- The support facility liaison officer for the Bangor Vet Center spent 1 day a week, he told us, at that vet center, 76 miles away.

Figure 7.1: Effect of Distance Between Vet Centers and Support Facilities on Whether Clinical Collaboration Occurred (Fiscal Year 1985)



[a] For vet centers that opened before fiscal year 1985.

- The support facility for the Oakland Vet Center had no clinical meetings with the center (35 miles away), according to the support facility liaison officer; however, a vet center staff member attended the nearby outpatient clinic's weekly staff meetings, a psychologist at the clinic told us, to discuss common matters.

Team leaders at three other centers told us that their staffs also regularly met with their support facilities or their support facilities' outpatient clinic to discuss clinical matters, but the meetings were less than weekly. All three vet centers were within 30 miles of their support facilities.

The remaining two centers (the Knoxville and Greenville Vet Centers) had no regular clinical meetings with their support facilities, both of which were over 100 miles away. Moreover, neither center had regular meetings with the outpatient clinic in its city. According to the Knoxville Vet Center team leader, the vet center staff were considered the experts on counseling Vietnam veterans. The Greenville Vet Center team leader consulted with the psychiatrist at the outpatient clinic in Greenville as needed, the leader said; the psychiatrist planned to come to the center weekly, beginning in October 1986, to provide clinical assistance.

Vet Center and Support Facility Staff Collaborated on Training Activities

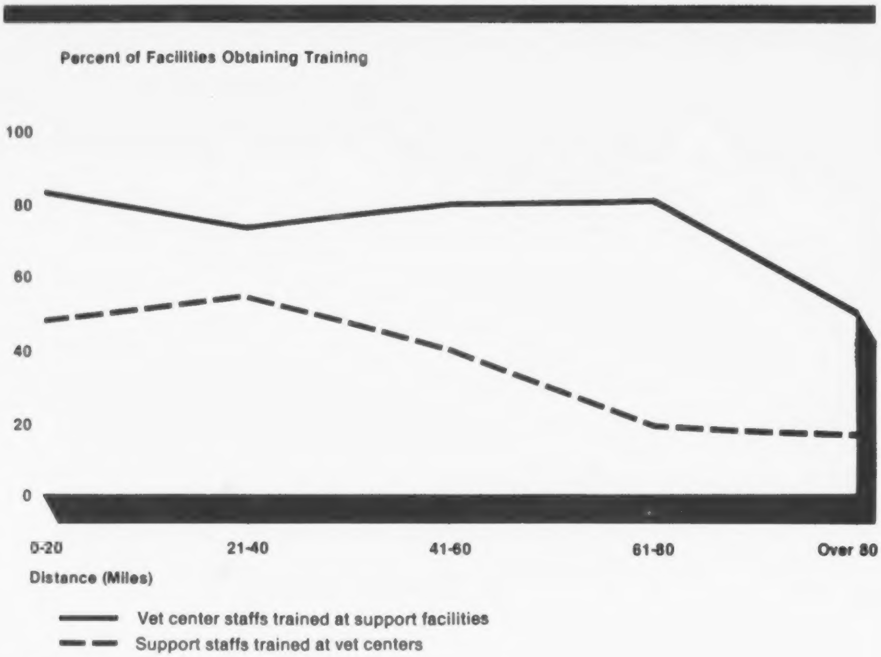
An associate deputy chief medical director's letter on professional collaboration, dated August 13, 1984, encouraged vet center and support facility staff to participate in each other's relevant professional continuing education and training activities. This would give them the opportunity, according to the letter, to exchange ideas and expertise and meet professional requirements; increase the understanding, diagnosis, and treatment of readjustment problems of Vietnam era veterans; and facilitate the availability of staff for clinical consultation.

The questionnaire responses indicated that, in fiscal year 1985, staff at about 75 percent of vet centers attended training at the support facility; staff at about 45 percent of the support facilities attended training at the vet centers. Training, officials told us, was in areas such as PTSD, suicide, and treatment of substance abusers. As shown in figure 7.2, however, the percentage of vet centers' staffs attending training at support facilities dropped once the distance between the two reached 80 miles; the percentage of support facility staff attending training at the vet centers dropped once the distance between the two reached 60 miles.

Of the three centers we visited that were 60 or more miles from their support facilities, staffs at two of them (the Knoxville and Greenville Vet Centers) had not attended training at the support facilities, according to officials interviewed. Moreover, officials said that these two vet centers also did not have staffs attend relevant training given by the support facilities' outpatient clinics in the same city as the vet centers.

Since 1982, no support facility staff from the facilities 60 or more miles from their vet centers, officials also said, had attended training given by the vet centers; however, the Knoxville Vet Center had provided training to the outpatient clinic staff in its city in 1985. More collaboration did not occur, vet center team leaders and support facility officials said, because relevant courses and seminars were not offered.

Figure 7.2: Effect of Distance Between Vet Centers and Support Facilities on Whether Training Obtained (Fiscal Year 1985)



[a]For vet centers that opened before fiscal year 1985.

Collaboration Between Vet Centers and PTSD Units Needs Strengthening

According to VA, many Vietnam veterans have PTSD, a syndrome created by severely stressful or traumatic events, such as military combat, seeing people die, or incarceration as a prisoner of war. Its symptoms include intense reliving of the event, anxiety, sleep disturbance, depression, social isolation, and an incapacity for intimate relations with others. The Veterans' Health Care Act of 1984 (Public Law 98-528, Oct. 19, 1984) authorized VA to designate special programs for the diagnosis and treatment of PTSD and required that when appropriate, the services provided under this program be coordinated with services provided by the Readjustment Counseling Program. As of November 1986, VA had designated special PTSD units at 13 of its medical centers.[1]

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[1] In addition to the 13 designated units, at least seven medical centers had set aside a defined physical space for treating PTSD patients.

Vet Center Clients Needing Inpatient PTSD Care Frequently Not Referred to PTSD Units

The responses to our questionnaire indicated that, in fiscal year 1985, vet centers that opened before October 1, 1984, together identified over 4,600 clients needing inpatient PTSD care; in fact, 99 percent of those centers identified clients in need of inpatient PTSD treatment. Eighty-eight percent referred a client to a PTSD unit. The centers, however, referred only one-quarter of their clients needing inpatient PTSD treatment to a PTSD unit. Eighty-one percent of the centers said that they treated some clients who needed inpatient care; 71 percent said that they referred some of these clients to support facilities for treatment.

The vet centers did not make more referrals primarily because of (1) lack of available beds, (2) distance, and (3) client needs and preferences.

- Lack of available beds: Three of the 12 support facilities visited (the Bay Pines, Northampton, and Palo Alto Medical Centers) had designated PTSD units. The Bay Pines unit, with 20 beds, and the Northampton unit, with 30 beds, were full, officials told us, and additional veterans were waiting to be admitted. According to the Bay Pines official, the average waiting period was 6 months. The director of the PTSD unit at Palo Alto, which had 90 beds, told us that 84 beds were filled. He said this was the normal occupancy, and veterans were rarely put on a waiting list unless it was their choice not to be immediately admitted. Officials at 8 of the 12 centers visited noted the unavailability of bed space as a reason for not making more referrals to the PTSD units.
- Distance: About three-quarters of all vet centers were 100 or more miles from the closest PTSD unit; about one-quarter were 450 or more miles away. At over half the centers (five of eight) we visited that were 100 or more miles from a PTSD unit, team leaders told us distance was a reason that they did not make more referrals.
- Client needs and preferences: At three centers we visited, team leaders told us they would not first refer a client to a PTSD unit if the client had an immediate need for hospitalization or required treatment for other problems. A veteran must be free from substance abuse and acute psychiatric illnesses, officials from two PTSD units told us, to be considered for admission. Moreover, clients may not want to be admitted to a PTSD unit, team leaders from four centers told us, because they do not want to be away from their families or jobs for an extended period of time. According to VA, most PTSD units plan for their patients to stay for from 3 to 5 months.

Limited Contact Existed Between Vet Centers and Designated PTSD Units

VA's Special Committee on PTSD, established by Public Law 98-528 to assess the agency's ability to treat veterans with the disorder, noted that continuity of care between vet centers and PTSD units may facilitate the treatment of those veterans and minimize their relapse. The committee also noted that coordination permitted the efficient use of resources at both locations. As of February 1987, VA did not have guidelines specifying how PTSD units and vet centers should coordinate their diagnosis and treatment of veterans with PTSD.

Vet centers that referred clients to PTSD units in fiscal year 1985, according to responses to our questionnaire, almost always notified the units of the referral by letter or telephone. After the referral, however, most of the centers had little contact with the unit, as shown in table 7.1.

Table 7.1: Contact Between Vet Centers and PTSD Units[a]

	Percent of centers that had contact:			
Type of contact	**Always/ almost always**	**Sometimes**	**Rarely/ never**	**Not applicable**
Telephone/letter notification of referral	92	5	2	1
Meeting/contact verifying diagnosis	41	16	35	7
Meeting/contact developing treatment plan for admitted veteran	16	18	55	11
Meeting/contact developing alternate plan in lieu of admission or while waiting for admission	25	20	45	10
Periodic meetings/ contacts discussing progress	26	23	38	13
Notification of patient discharge	26	20	41	13
Meeting/contact establishing follow-up treatment plan	27	20	41	12
Meeting/contact discussing progress in follow-up treatment plan	12	23	50	16

[a] For vet centers that opened before October 1, 1984.

The questionnaire responses did not clearly indicate that distance between vet centers and the PTSD units was a factor in coordination. The majority of centers visited that referred clients to PTSD units in fiscal year 1985 did not fully communicate with the units, for example:

- The Knoxville Vet Center center referred four clients to PTSD units in fiscal year 1985, the team leader there said; he did not, however, know if two of them had been admitted because the units in the Bay Pines and Cleveland Medical Centers did not provide him feedback.
- According to vet center and PTSD unit officials, staff from only one of the four centers we visited that were within 40 miles of a PTSD unit participated in the unit's inpatient treatment program. A St. Petersburg Vet

Center counselor told us that center staff conducted group sessions at the nearby PTSD unit in the Bay Pines Medical Center.

- The Pawtucket Vet Center team leader told us his staff seldom contacted clients in the program who were referred to the PTSD unit in the Northampton Medical Center; the vet center staff did not communicate at all with the PTSD unit staff during the clients' stay. According to the team leader, this was because the PTSD unit staff assumed full responsibility for the treatment of the veterans.
- The Albuquerque Vet Center team leader told us that although the center had eight clients admitted to the PTSD unit in the Topeka Medical Center in fiscal year 1985, staff from the two facilities did not discuss clients' treatment options following hospitalization. He said the vet center independently developed its own posthospitalization treatment plans.

Conclusions

Most vet centers and support facilities collaborated in some way on administrative, clinical, and training matters. Clinical and training collaboration, however, was affected by the distance between the vet center and its support facility. Because some vet centers are closer to satellite outpatient clinics than to their designated support facility, we believe VA should consider linking more vet centers to these clinics, if the clinics can provide the support needed by the centers.

In addition to the law requiring, when appropriate, that PTSD and vet center services be coordinated, the Special Committee on PTSD has indicated that close contact between the vet centers and specialized PTSD inpatient units could improve the effectiveness of the treatment provided the veterans. Although VA may not be able to overcome many of the reasons limiting referrals from vet centers to inpatient PTSD units, we believe it can improve the coordination between the units once referrals are made. Better communication could be accomplished through telephone and written correspondence if distance precludes face-to-face contact. This communication would help assure veterans received coordinated care before, during, and after their stays at PTSD units; if they were not admitted to the units, this communication would help assure that they received appropriate alternative care.

Recommendations to the Administrator of Veterans Affairs

We recommend that the Administrator direct the chief medical director to

- determine whether any outpatient clinic located closer than the current support facility could better provide clinical and training support to a vet center and
- strengthen collaboration between vet centers and PTSD units by requiring these facilities to establish formal communication concerning all clients referred from one to the other.

Agency Comments

In his June 11 letter, the Administrator concurred with both recommendations. By July 31, 1987, he expects to forward guidance to the field (1) instructing vet centers and VA outpatient clinics that are near each other to participate in each other's clinical and training activities and (2) requiring collaboration between vet centers and PTSD units, according to standards of sound clinical practice. The Administrator stated that increased information sharing between the PTSD units and vet centers had already begun, including the participation of vet center staff in PTSD regional conferences.

Chapter 8

Monitoring Vet Center Activities Could Be Enhanced

Regional office staff are required to make periodic clinical and administrative site visits to vet centers. Because of staff shortages and other time demands, however, staff at the regional offices we visited were not making as many of these visits as required. The Readjustment Counseling Service has other mechanisms, such as periodic reports, teleconference calls, and group meetings, for monitoring program activities and keeping communication between facilities open. Generally, these mechanisms were being used. Because site visits are critical mechanisms that regional staffs have for monitoring certain program activities and identifying areas needing improvement, we believe site visits should be made as required.

Site Visits Not Made as Required

The Readjustment Counseling Service director considered site visits to vet centers by regional office staff to be a critical part of the effective management of the program. He told us that such visits are important to bridge the geographic distance between team leaders and their regional supervisors and to monitor program elements that cannot be monitored through other mechanisms. According to the director, administrative site visits are needed to observe the appearance and use of the center, the adequacy of staff meetings, relations with support facilities, and staff competence and functioning; clinical site visits are needed to evaluate the centers' clinical operations, including reviewing clinical files and evaluating the centers' clinical collaboration with their support facilities.

We reviewed reports of site visits made, in fiscal year 1985, to the centers we visited and found that most reports documented problems or issues needing management attention. For example, the report of a clinical visit to the Jackson Vet Center noted that the center needed to improve clinical services to couples and significant others and increase outreach efforts to female and Native American veterans. The reports of clinical visits to the Boston and San Jose Vet Centers noted that their clinical filing systems needed overhaul and that client follow-up and case closing were inadequate.

The regional offices' fiscal year 1985 management objectives required that officials make a specified number of site visits. The requirement varied among regions, but generally regional staff had to evaluate each center's administrative and clinical operations at least once during the year. For associate regional managers for Counseling, performance requirements specifically required them to make three clinical site visits a month, visiting each center at least once during the year. The content of clinical site visits was specified by a program-wide report format. The format used between December 1984 and June 1986 covered an assessment of centers' counseling and other services provided, staff development and interaction, outreach and community networking, and relations with support facilities. In June 1986, the clinical site visit report format was changed to focus more on clinical, rather than administrative, issues. The content of administrative site visits was not specified. The regional officials we interviewed, however, noted a variety of topics that they covered during such visits, including staff burnout; team performance and interactions; productivity; relations with support facilities, community organizations, and clients; and some clinical issues.

The regions we visited did not always conduct the number of site visits, particularly administrative visits, as required by their management objectives, but in fiscal year 1985 regional officials did make clinical visits to 10 of the 12 centers we visited, as shown in table 8.1.

Table 8.1: Site Visits Made by Regional Officials (Fiscal Year 1985)

Region	Requirement	Vet center	Visits made
I	At least four administrative/ clinical visits to each center; at least one in-depth clinical assessment of each center	Pawtucket, RI Springfield, MA Bangor, ME Boston, MA	1 clinical 1 clinical 1 administrative/ clinical[a] 1 clinical[b]
III	At least two administrative/ clinical visits to each center; at least two in-depth clinical assessments of each center	Jackson, MS St. Petersburg, FL Knoxville, TN Greenville, SC	1 clinical; 1 administrative 1 clinical 1 clinical 1 administrative
VI	At least one administrative and one clinical visit to each center	Oakland, FL San Jose, CA Albuquerque, NM Las Vegas, NV	2 clinical; 1 administrative 1 clinical 1 clinical none

[a] The region I regional manager told us this visit was made, but he could not provide us with documentation.

[b] In addition, region I officials made four special-purpose visits to the Boston Vet Center. Three were to review the center's monitoring of program contractors, and one was to interview candidates for vacant vet center positions.

The regional officials interviewed noted that they were not making site visits as required mainly because of staff and funding shortages and the demands of other responsibilities. Concerning staff shortages, the region VI regional manager told us he was on sick leave for 4 months in fiscal year 1985, leaving the deputy regional manager to handle operations alone. From January 1985 to August 1985, the region I regional manager served as both acting regional manager and associate regional manager for Counseling. The priority placed by the director on making clinical visits, officials at two regional offices visited noted, caused funding shortages for making administrative site visits.[1]

Officials at all three regions visited said their other responsibilities limited the number of site visits they could make. For example, the regional managers in regions I and III said they spent much of their time in fiscal year 1985 on activities related to the opening of new centers. One of the two associate regional managers for Counseling in region VI told us she had other responsibilities, such as coordinating regional training, that prevented her from making all the site visits required. She also noted that region VI covered a large geographic area, making travel difficult. She said she had been able to make an average of only two clinical site visits a month. Effective July 1, 1986, the Readjustment Counseling Service created a seventh program region, in part to ease the travel and workload burden of region VI. Ten of the 43 centers that were in region VI are now in region VII.

Other Monitoring and Communication Mechanisms Being Used

In addition to making site visits, regional offices monitor their vet centers by requiring them to submit periodic reports, participate in teleconference calls, and attend regional meetings. The Readjustment Counseling Service's central office, in turn, does the same with the regional offices. We found that, in general, the central office and the regional offices we visited were using these monitoring and communication mechanisms.

The three regions we visited required their vet centers to submit quarterly reports on personnel changes, use of supplementary staff, community activities, clinical and administrative contacts with VA staff, and crisis events. (Region III also required monthly reports.) Regions I and III requested their centers to submit additional information on program operations, such as (for region III) a description of group counseling sessions held and staff continuing education activities. The central office, in turn, required the regions to submit quarterly reports summarizing their centers' activities.

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[1] In the early years of the program, VA did not obligate all funds available, either reprogramming funds to other programs or allowing them to lapse. In fiscal year 1985, however, VA obligated 99.4 percent of the funds available to the vet center program.

Most regions' management objectives required the regional staff to conduct weekly conference calls with their vet centers to discuss and disseminate program information. Generally, both regions III and VI regional managers conducted the weekly calls; regional officials told us that all centers participated in these calls. Region I management objectives did not require conference calls with vet centers, but the regional manager conducted them generally twice a month. He said all team leaders usually participated in these calls. The director also conducted weekly conference calls with the regional staffs.

All three regions visited held at least one meeting (including a training session) for their team leaders in fiscal year 1985. As discussed in chapter 5, these meetings covered administrative and clinical issues. The central office conducted quarterly meetings for regional and deputy regional managers to discuss current program issues.

Conclusions

Regional officials' site visits to vet centers are useful in managing program operations because the centers are geographically distant from program supervisors and physically separated from other VA facilities. Some reasons officials gave for not making more frequent site visits no longer exist. For example, a seventh regional office was established partly to ease the workload on region VI, and the tasks of program expansion have been completed. In addition, as of December 1986 all seven regions had permanent regional managers and, with the exception of one vacancy, associate regional managers for Counseling.

As mentioned in chapter 2, program funding is not expected to increase. However, program costs will probably increase because of pay raises and other inflationary effects. Therefore, we would expect the regional management to have more funding shortages and more difficulty making the required number of clinical and administrative site visits. We believe that program managers in the central office should monitor the extent to which regional managers are making required site visits and, if necessary, adjust the requirements to be consistent with funding available. For those centers where regional managers are not able to make enough site visits to adequately monitor activities, the program may want to rely on input from the centers' support facilities.

Recommendations to the Administrator of Veterans Affairs

We recommend that the Administrator direct the chief medical director to do the following: (1) emphasize the need for regional officials to make their required site visits; (2) monitor whether the officials are making the visits as required; and (3) where not enough visits are being made, request that the support facilities monitor the administrative and clinical activities at the centers.

Agency Comments

In his June 11 letter, the Administrator concurred with these recommendations. He stated that during April 1987 all regional management officials were instructed to complete the required number of administrative and clinical site visits for fiscal year 1987. A monthly report to the central office from each region, documenting the number of visits made in the fiscal year to date, was instituted.

Chapter 9

VA Has Little Assurance That Vet Centers Provided Quality Care to Clients

VA has little assurance that vet centers provided high quality care to their clients. Neither the VA central office nor centers' support facilities routinely conducted program quality assurance reviews. Moreover, less than adequate clinical recordkeeping practices and file review procedures limited the extent to which the quality of care could be assessed.

Quality Assurance Reviews Not Conducted

Providing quality health care is one of VA's primary goals. To assure that its medical centers provide quality care, VA has developed two programs (as required by 38 C.F.R. 17.500): (1) the systematic external review program, involving DM&S regional office reviews[1] of the quality of care provided by each medical center and the center's quality assurance program and (2) the systematic internal review, involving individual medical center reviews of the quality of care provided to its patients. The internal review must include continuous monitoring of key indicators of the quality of care provided, including reviews of psychiatric programs and medical records.

The systematic external review program applies to all VA medical facilities, but vet centers are not included in VA's definition of a medical facility (38 C.F.R. 17.500 (d)). In July 1986, the Readjustment Counseling Service director told us systematic external reviews of vet centers had never been conducted.

VA medical center directors, who are responsible for implementing the systematic internal reviews, are given considerable flexibility in how they carry out this function. Support facility officials told us that none of the centers we visited, with the exception of the Knoxville Vet Center, were included in internal reviews. According to a Knoxville Vet Center support facility official, that vet center is included in the suport facility's internal reviews. We found, however, that the center's involvement was limited to annual self-assessments.

Although we did not ask specifically, officials from three support facilities told us they conducted vulnerability assessments[2] of their vet centers. For example, based on an assessment of the Springfield Vet Center in fiscal year 1985, the support facility liaison officer reviewed five client records and the vet center staff's crisis intervention capabilities. The review indicated that (1) the files were appropriately documented except for notes on administrative, financial, or benefits issues and (2) the staff knew the resources available to deal with problem situations and received crisis intervention training.

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[1] During fiscal year 1986, DM&S switched responsibility for these external reviews from the central office to the DM&S regional offices (which, as mentioned in ch. 1, are distinct from the Readjustment Counseling Service regional offices).

[2] The vulnerability assessment is part of the internal control system required by the Federal Managers' Financial Integrity Act of 1982. It is a review of the susceptibility of a program to unauthorized use of resources, errors in reports and information, illegal or unethical acts, or adverse public opinion.

Clinical Recordkeeping Practices and File Review Requirements Not Adequate

VA requires its vet centers to maintain clinical notes so that the counseling process can be effectively managed. It further requires regional officials and team leaders to review the clinical folders to ensure that "quality readjustment counseling services" are provided. However, our review of the 12 vet centers and 3 regional offices indicated that (1) clinical recordkeeping varied among counselors but was generally not adequate and (2) file review requirements did not specify the frequency, magnitude, or content of the reviews, or how they should be documented.

Clinical Recordkeeping Not Adequate

Since June 1982 vet center staff have been required to develop individual counseling plans for clients, including a description of the client's problem(s), pertinent background information, and the actions intended to be taken to resolve the problem(s). Once a counseling plan had been established, staff were also required to regularly prepare progress notes and to prepare a case-closing summary describing the status of the client's functioning at the time of case closing. Over the course of the program, the recordkeeping requirements have become more specific. For example, in August 1984 a specific format was required for recording progress notes.

Three of the nine clinical site visit reports on vet centers that we reviewed noted clinical recordkeeping problems. An assistant regional manager for Counseling told us that a fourth center also had problems, but these problems were not documented in the center's site visit report. In one case, the person who was team leader at the center throughout most of fiscal year 1985, we were told, did not require his staff to prepare clinical notes because he wanted to assure that information about each client remained confidential.

Two remaining centers that had recordkeeping problems were in region VI. According to an October 1985 report from its two assistant regional managers for Counseling, not all counselors had the skills necessary to maintain adequate clinical records; this impression was based on visits to almost every center in that region. In June 1986, one of the assistant regional managers for Counseling told us that clinical recordkeeping was still a problem but was improving.

In fiscal year 1985, all three regions visited provided training in clinical recordkeeping to their staff. The assistant regional managers for Counseling also told us they provided individual assistance as necessary during site visits, distributed examples of good clinical notes, and discussed requirements during regional conference calls.

The principal psychologist on our staff reviewed a sample of 100 clinical files from the 12 centers visited to determine the extent to which the clinical notes contained the basic information required. She found that about one-third of the files inadequately documented the reasons for the clients' visits and the assistance given them. Forty-four percent of the files inadequately documented the clients' progress since the initial visit and the counselors' current plans for resolving the clients' problems, for example:

- According to contact sheets submitted to the data processing center (see ch. 4), one client came to the Boston Vet Center about once a month between April 1985 and November 1985, but no progress notes were ever written describing the client's problems, what was being done to assist her, or the progress she made.
- According to contact sheets, a client came to the San Jose Vet Center five times between April 1984 and May 1985, but no progress notes were written describing the client's problems, the client's progress, or the assistance provided.
- Progress notes for a client who came twice to the Bangor Vet Center in 1984 stated only "vet entered into system" and "vet in for coffee and rap."
- According to progress notes, a client attended 22 group-counseling sessions at the Pawtucket Vet Center between March and November 1985, but the notes did not indicate the client's progress in resolving his problems during this period.

In contrast to these examples, the following is a description of adequate documentation:

- Progress notes indicated that a client and his wife together or separately had eleven contacts with the Knoxville Vet Center in the summer of 1984. In this case, the progress notes extensively described the client's problem, assistance given him and his wife, and the progress he had made in resolving his problem.

File Review Procedures Were Not Specific

An August 1984 DM&S circular states the following: To ensure "quality readjustment counseling services" and appropriate clinical documentation, the assistant regional managers for Counseling and team leaders are responsible for reviewing client folders of each vet center staffer with counseling duties. The circular, however, does not specify the frequency, magnitude, or content of the reviews, or how they should be documented.

According to the circular, the assistant regional managers for Counseling and team leaders are required to "periodically" review vet centers' files. The assistant regional managers, at the three regions we visited, said they reviewed files during their clinical site visits. This meant that they reviewed files only once, during fiscal year 1985, at nine centers they visited, twice at one center, and not at all at two centers. The frequency of most team leader reviews at the sites we visited varied from weekly to quarterly. One team leader said that he did not review files at all. Another said that his reviews occurred when he happened to (1) see another counselor's client and thus had reason to look through that client's files or (2) be at the file cabinet to pull one of his files and decided to randomly select two or three others for review.

In addition, the DM&S circular does not require that a specific number of files be reviewed by assistant regional managers for Counseling and team leaders.[3] The number reviewed at the centers visited varied. For example, some team leaders told us they examined a total of 10 or fewer files during their monthly or quarterly reviews; others told us that they reviewed the files of every active client. The region I regional manager told us that when he made clinical site visits in fiscal year 1985, he reviewed 10 to 12 files at each site. Officials from the other two regions visited told us that they reviewed as many as 20 during each visit. One purpose of the file review is to assess the quality of services provided. However, the site visit report format used from December 1984 through June 1986 did not explicitly require assistant regional managers for Counseling to comment on the quality of care provided. The current site visit report format requires assistant regional managers for Counseling to examine documentation, but does not explicitly require them to examine the quality of care provided. Of the nine site visit reports we reviewed, only one (the report on the Knoxville Vet Center) addressed quality of care. Moreover, two team leaders told us that their reviews were primarily for the purpose of identifying inactive cases.

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[3] A December 1986 draft Program Guide requires team leaders to review each case at least once during the counseling process.

Finally, the DM&S circular does not require assistant regional managers for Counseling and team leaders to document their reviews of individual case files.[4] Officials from the two regions we questioned (regions I and III) said they documented their reviews in site visit reports, but did not document the reviews in the individual case files. Six of the 11 team leaders who reviewed files told us they did not document their reviews of individual files.

Conclusions

Although the Readjustment Counseling Service established mechanisms to assure quality care (clinical file reviews by regional officials and team leaders), it had little assurance that its centers were providing quality care because clinical recordkeeping practices and file review procedures were not adequate. We believe that, as part of DM&S, the Readjustment Counseling Service should be subject to the same quality reviews, including the systematic internal reviews made by medical centers, as DM&S's other health care delivery services.

Recommendations to the Administrator of Veterans Affairs

We recommend that the Administrator, through the chief medical director,

- require the DM&S regional offices to include the vet centers in their systematic external review programs;
- require medical center directors to include vet centers in their systematic internal reviews; and
- establish specific requirements for regional and team leader reviews of clinical files, including specifying the minimum frequency, magnitude, and documentation requirements, as well as requiring the reviewers to comment on quality of care provided to clients.

Agency Comments

In his June 11 letter, the Administrator concurred with the first and third recommendations. He stated that by the end of fiscal year 1987, a task force will provide recommendations for accomplishing the systematic external reviews of vet centers. In addition, VA is revising the site visit format for regional management to indicate minimum frequency and documentation requirements for reviews of clinical files. VA did not, however, address our recommendation to establish specific requirements for team leader reviews of clinical files.

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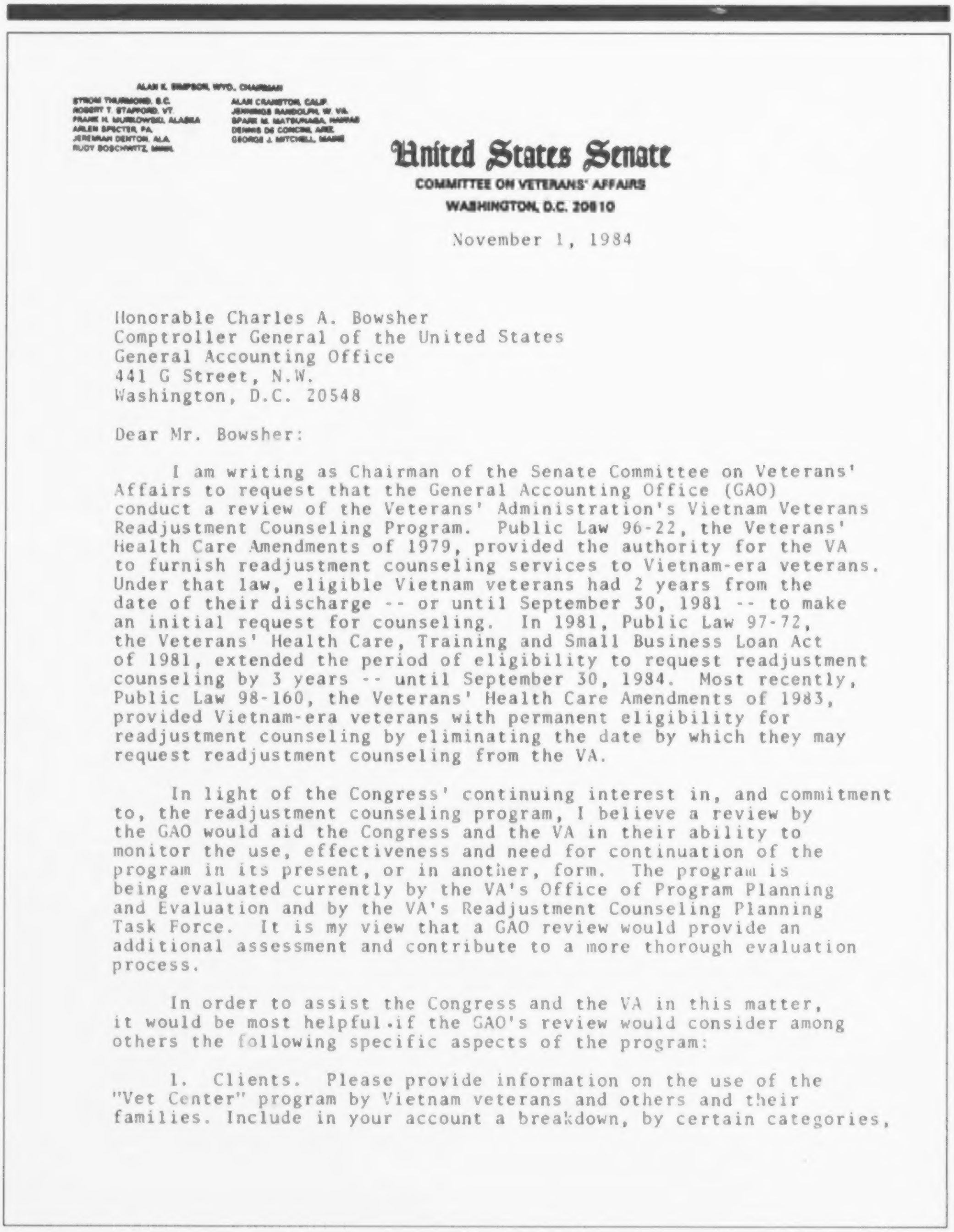
[4] The December 1986 draft Program Guide requires the reviewer to sign the file to indicate the case was reviewed.

VA agreed in principle with our second recommendation. According to the Administrator, the vet center team leaders and regional management staff will begin conducting systematic internal reviews; however, it would be inappropriate to require medical center directors to include vet centers in their systematic internal review activities because medical centers do not direct vet center operations. But medical center directors may, he added, conduct internal reviews of selected aspects of vet centers as part of the medical center's internal review program.

Request Letter



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United States Senate
COMMITTEE ON VETERANS' AFFAIRS
WASHINGTON, D.C. 20510

November 1, 1984

Honorable Charles A. Bowsher
Comptroller General of the United States
General Accounting Office
441 G Street, N.W.
Washington, D.C. 20548

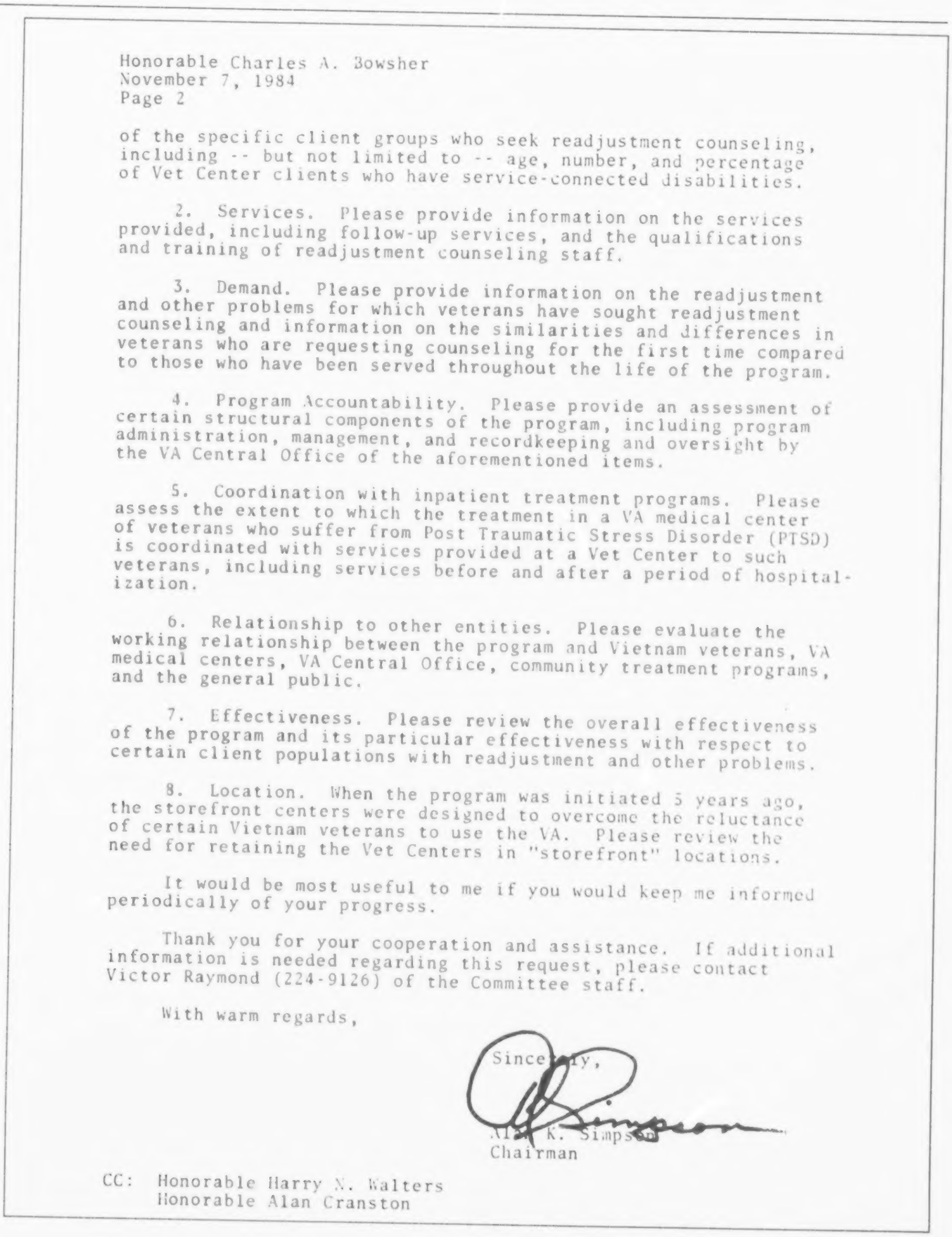
Dear Mr. Bowsher:

I am writing as Chairman of the Senate Committee on Veterans' Affairs to request that the General Accounting Office (GAO) conduct a review of the Veterans' Administration's Vietnam Veterans Readjustment Counseling Program. Public Law 96-22, the Veterans' Health Care Amendments of 1979, provided the authority for the VA to furnish readjustment counseling services to Vietnam-era veterans. Under that law, eligible Vietnam veterans had 2 years from the date of their discharge -- or until September 30, 1981 -- to make an initial request for counseling. In 1981, Public Law 97-72, the Veterans' Health Care, Training and Small Business Loan Act of 1981, extended the period of eligibility to request readjustment counseling by 3 years -- until September 30, 1984. Most recently, Public Law 98-160, the Veterans' Health Care Amendments of 1983, provided Vietnam-era veterans with permanent eligibility for readjustment counseling by eliminating the date by which they may request readjustment counseling from the VA.

In light of the Congress' continuing interest in, and commitment to, the readjustment counseling program, I believe a review by the GAO would aid the Congress and the VA in their ability to monitor the use, effectiveness and need for continuation of the program in its present, or in another, form. The program is being evaluated currently by the VA's Office of Program Planning and Evaluation and by the VA's Readjustment Counseling Planning Task Force. It is my view that a GAO review would provide an additional assessment and contribute to a more thorough evaluation process.

In order to assist the Congress and the VA in this matter, it would be most helpful if the GAO's review would consider among others the following specific aspects of the program:

1. Clients. Please provide information on the use of the "Vet Center" program by Vietnam veterans and others and their families. Include in your account a breakdown, by certain categories,



Honorable Charles A. Bowsher
November 7, 1984
Page 2

of the specific client groups who seek readjustment counseling, including -- but not limited to -- age, number, and percentage of Vet Center clients who have service-connected disabilities.

2. Services. Please provide information on the services provided, including follow-up services, and the qualifications and training of readjustment counseling staff.

3. Demand. Please provide information on the readjustment and other problems for which veterans have sought readjustment counseling and information on the similarities and differences in veterans who are requesting counseling for the first time compared to those who have been served throughout the life of the program.

4. Program Accountability. Please provide an assessment of certain structural components of the program, including program administration, management, and recordkeeping and oversight by the VA Central Office of the aforementioned items.

5. Coordination with inpatient treatment programs. Please assess the extent to which the treatment in a VA medical center of veterans who suffer from Post Traumatic Stress Disorder (PTSD) is coordinated with services provided at a Vet Center to such veterans, including services before and after a period of hospitalization.

6. Relationship to other entities. Please evaluate the working relationship between the program and Vietnam veterans, VA medical centers, VA Central Office, community treatment programs, and the general public.

7. Effectiveness. Please review the overall effectiveness of the program and its particular effectiveness with respect to certain client populations with readjustment and other problems.

8. Location. When the program was initiated 5 years ago, the storefront centers were designed to overcome the reluctance of certain Vietnam veterans to use the VA. Please review the need for retaining the Vet Centers in "storefront" locations.

It would be most useful to me if you would keep me informed periodically of your progress.

Thank you for your cooperation and assistance. If additional information is needed regarding this request, please contact Victor Raymond (224-9126) of the Committee staff.

With warm regards,

Sincerely,

AK Simpson

Alan K. Simpson
Chairman

CC: Honorable Harry N. Walters
Honorable Alan Cranston

Selected Characteristics of Vet Centers (as Reported in Questionnaires)

Vet center	Year began operation	Location of center	Location of clients
Albany, NY	1982	U[b]	C[c]
Albuquerque, NM[a]	1980	U	U/S[c]
Amarillo, TX	1986	U	•
Anaheim, CA	1981	U	U/S
Anchorage, AK	1980	U	U/S
Arecibo, PR	1985	U	C
Atlanta, GA	1980	U	U/S
Austin, TX	1985	U	U/S
Avon, MA	1980	S	C
Babylon, NY	1982	S[b]	U/S
Baltimore, MD	1980	U	U/S
Baltimore, MD	1980	U	U/S
Bangor, ME[a]	1982	R[b]	R/S[c]
Billings, MT	1980	R	R/S
Biloxi, MS	1985	U	U/S
Birmingham, AL	1980	U	U/S
Boise, ID	1979	R	•
Bossier, LA	1985	S	R/S
Boston, MA[a]	1980	U	U/S
Boulder, CO	1985	U	U/S
Brighton, MA	1980	S	U/S
Bronx, NY	1980	U	U/S
Brooklyn, NY	1981	U	U/S
Buffalo, NY	1980	U	U/S
Casper, WY	•	U	C

Vietnam era veteran population	Vietnam era veteran race/ethnic origin[d] (percent) White	Black	Other	Male Vietnam era veterans (percent)	Distance to VA support facility (miles)	Vietnam era veterans needing PTSD treatment[e] (percent)	Distance to nearest designated PTSD unit (miles)
65,046	88	10	2	99	3	30	60
55,000	45	2	53	99	8	25	700
14,000	80	5	15	98	6	•	•
78,000	80	2	18	99	20	10	450
22,000	90	4	6	98	8	60	•
20,000	0	0	100	100	98	2	•
131,910	69	30	1	99	7	65	180
36,550	67	15	18	95	67	30	700
64,000	95	2	5	98	6	50	•
70,000	75	14	11	95	20	15	100
25,000	45	45	10	95	6	50	100
83,630	65	35	0	75	8	35	75
22,000	95	0	5	96	76	36	330
15,000	85	1	14	97	150	15	•
44,000	75	24	2	99	20	15	400
36,000	70	30	0	99	1	30	300
40,000	96	0	4	96	1	4	600
40,000	50	50	0	98	4	•	850
18,480	70	23	7	94	5	•	200
25,000	75	5	20	90	35	20	450
72,000	63	25	12	98	5	100	110
26,000	5	55	40	98	1	60	15
50,000	32	50	16	98	8	10	50
48,950	57	37	6	98	8	60	•
14,000	70	3	27	80	189	10	•

(continued)

[a] Vet center included in GAO review.

[b] U = urban, S = suburban, and R = rural.

[c] C = combined, U/S = urban/suburban, and R/S = rural/suburban.

[d] Totals may not equal 100 percent because we accepted questionnaire respondents' figures if they totaled 90-110 percent.

[e] Number of Vietnam era veterans identified as needing inpatient PTSD treatment in fiscal year 1985.

Note: A blank indicates no response.

Vet center	Year began operation	Location of center	Location of clients
Charlotte, NC	1982	U	•
Chattanooga, TN	1985	S	R/S
Cheyenne, WY	1980	R	R/S
Chicago, IL	1979	U	U/S
Chicago Hts, IL	1982	S	U/S
Chicago Hts, OH	1980	S	U/S
Cincinnati, OH	1980	U	U/S
Cleveland, OH	1980	U	U/S
Colorado Springs, CO	1981	S	U/S
Columbia, SC	1985	U	U/S
Columbus, OH	1980	U	U/S
Concord, CA	1982	S	U/S
Corpus Christi, TX	1985	U	C
Dallas, TX	1980	U	U/S
Dayton, OH	1979	U	U/S
Denver, CO	1980	U	U/S
Des Moines, IA	1980	U	U/S
Duluth, MN	1984	U	C
El Paso, TX	1980	S	U/S
Elkton, MD	1979	R	R/S
Erie, PA	1985	U	U/S
Eugene, OR	1981	R	R/S
Eureka, CA	1986	R	R/S
Evansville, IN	1981	U	C
Fairbanks, AK	1980	U	U/S

Vietnam era veteran population	Vietnam era veteran race/ethnic origin[d] (percent) White	Black	Other	Male Vietnam era veterans (percent)	Distance to VA support facility (miles)	Vietnam era veterans needing PTSD treatment[e] (percent)	Distance to nearest designated PTSD unit (miles)
45,020	85	14	3	97	50	11	251
21,000	48	35	12	94	125	14	250
25,000	80	1	19	99	1	25	600
55,000	40	46	14	95	3	11	35
95,000	40	25	33	95	40	30	60
183,420	68	18	14	98	4	10	23
48,500	48	30	2	95	200	25	300
187,240	70	20	10	90	25	9	25
50,000	70	20	10	80	60	1	700
30,000	65	35	5	98	8	8	64
43,000	72	26	3	98	4	6	130
225,000	70	10	20	90	10	30	65
20,000	30	10	60	99	150	5	1,000
85,450	58	25	17	93	14	23	750
45,650	80	18	2	85	8	18	•
120,000	70	10	19	99	3	10	600
60,000	91	5	4	96	2	20	300
36,000	90	0	10	95	170	18	235
34,500	30	3	67	99	5	5	450
16,980	80	20	0	99	16	8	45
22,570	80	15	5	95	2	25	125
35,800	96	1	13	99	70	5	300
5,000	92	3	5	90	210	4	300
47,000	93	7	0	96	96	17	320
8,000	95	2	3	97	460	65	2,200

(continued)

[a] Vet center included in GAO review.

[b] U = urban, S = suburban, and R = rural

[c] C = combined, U/S = urban/suburban, and R/S = rural/suburban

[d] Totals may not equal 100 percent because we accepted questionnaire respondents' figures if they totaled 90-110 percent.

[e] Number of Vietnam era veterans identified as needing inpatient PTSD treatment in fiscal year 1985.

Note: A blank indicates no response.

Vet center	Year began operation	Location of center	Location of clients
Fargo, ND	1980	S	R/S
Fayetteville, NC	1980	U	U/S
Fresno, CA	1982	U	U/S
Ft Lauderdale, FL	1979	U	U/S
Ft Wayne, IN	1980	U	U/S
Ft Worth, TX	1982	U	U/S
Gallup, NM	1981	R	R/S
Gary, IN	1986	S	U/S
Grand Rapids, MI	1982	U	U/S
Grants Pass, OR	1985	R	R/S
Greensboro, NC	1986	S	C
Greenville, NC	1986	U	C
Greenville, SC[a]	1982	U	U/S
Harrisburg, PA	1982	U	U/S
Hartford, CT	1980	U	C
Honolulu, HI	1980	U	U/S
Houston, TX	1980	U	U/S
Houston, TX	1985	U	U/S
Huntington, WV	1980	R	R/S
Huntington, WV	1980	U	C
Indianapolis, IN	1980	U	U/S
Jackson, MS[a]	1980	R	R/S
Jacksonville, FL	1980	U	U/S
Jersey City, NJ	1979	U	U/S
Johnson City, TN	1985	R	R/S

Vietnam era veteran population	Vietnam era veteran race/ethnic origin[d] (percent)			Male Vietnam era veterans (percent)	Distance to VA support facility (miles)	Vietnam era veterans needing PTSD treatment[e] (percent)	Distance to nearest designated PTSD unit (miles)
	White	Black	Other				
20,000	70	5	25	90	7	•	•
75,000	68	28	4	90	3	20	500
65,000	69	6	25	95	4	52	•
93,000	70	15	15	98	30	36	300
60,000	84	12	4	95	2	25	200
43,050	88	7	5	96	40	20	500
10,000	8	3	89	95	150	10	322
30,000	50	30	20	95	50	20	100
102,070	86	10	6	99	56	20	190
30,000	97	1	3	99	30	•	400
65,000	60	35	5	90	60	10	300
30,000	40	60	0	97	125	17	600
40,000	79	20	1	95	110	75	125
76,000	80	17	3	91	35	60	90
54,500	70	25	5	95	9	30	52
38,000	35	1	64	96	2	48	2,500
105,000	30	60	10	98	3	107	728
103,000	58	26	16	99	13	10	500
39,000	90	10	0	95	12	20	350
30,000	90	9	2	99	60	2	300
163,190	86	12	2	97	3	15	197
42,000	55	40	5	98	4	75	450
38,280	60	35	5	93	71	50	211
98,970	40	30	30	98	12	60	40
45,000	90	5	5	98	2	9	350

(continued)

[a] Vet center included in GAO review.

[b] U = urban, S = suburban, and R = rural.

[c] C = combined, U/S = urban/suburban, and R/S = rural/suburban.

[d] Totals may not equal 100 percent because we accepted questionnaire respondents' figures if they totaled 90-110 percent.

[e] Number of Vietnam era veterans identified as needing inpatient PTSD treatment in fiscal year 1985.

Note: A blank indicates no response.

Vet center	Year began operation	Location of center	Location of clients
Kansas City, MO	1979	U	U/S
Kenai, AK	1981	U	U/S
Knoxville, TN[a]	1982	U	U/S
Laredo, TX	1980	U	U/S
Las Vegas, NV[a]	1980	U	U/S
Lexington, KY	1982	U	C
Lincoln, NE	1981	U	U/S
Lincoln Park, MI	1980	S	U/S
Little Rock, AR	1980	U	U/S
Los Angeles, CA	1980	U	U/S
Los Angeles, CA	1979	U	U/S
Louisville, KY	1980	U	U/S
Lowell, MA	1985	U	U/S
Lubbock, TX	1986	R	U/S
Madison, WI	1982	U	•
Manchester, NH	1980	U	U/S
Manhattan, NY	1980	U	U/S
Martinsburg, WV	1985	U	R/S
McAllen, TX	1980	U	U/S
Memphis, TN	1980	U	U/S
Miami, FL	1980	U	U/S
Midland, TX	1986	R	R/S
Milwaukee, WS	1980	U	U/S
Minot, ND	1982	R	R S
Missoula, MT	1985	S	U/S

Vietnam era veteran population	Vietnam era veteran race/ethnic origin[d] (percent) White	Black	Other	Male Vietnam era veterans (percent)	Distance to VA support facility (miles)	Vietnam era veterans needing PTSD treatment[e] (percent)	Distance to nearest designated PTSD unit (miles)
55,000	60	30	10	95	3	4	60
2,000	90	1	6	98	150	•	•
65,000	84	13	3	98	185	•	360
2,500	10	0	90	98	150	10	1,100
30,000	67	15	23	85	2	5	250
26,499	91	9	0	99	1	25	300
13,570	80	5	15	95	6	5	250
160,970	60	32	8	98	4	35	200
88,000	80	18	2	95	5	700	640
250,000	8	75	17	96	10	•	620
377,000	64	23	13	97	4	20	400
60,990	75	21	4	98	7	8	130
27,000	94	2	4	99	33	5	95
14,000	60	17	24	92	128	•	•
80,000	88	10	2	99	4	15	100
30,000	98	1	1	96	1	60	100
46,000	15	40	45	90	3	20	40
35,000	92	5	3	97	4	5	200
13,500	30	1	69	99	2	5	1,200
75,000	45	45	10	97	2	5	400
70,000	40	35	25	97	3	250	250
32,000	69	6	25	98	45	•	•
67,000	70	20	10	92	3	35	65
15,000	92	1	8	98	278	7	•
•	50	10	40	80	120	•	600

(continued)

[a] Vet center included in GAO review

[b] U = urban, S = suburban, and R = rural

[c] C = combined, U/S = urban/suburban, and R/S = rural/suburban

[d] Totals may not equal 100 percent because we accepted questionnaire respondents' figures if they totaled 90-110 percent

[e] Number of Vietnam era veterans identified as needing inpatient PTSD treatment in fiscal year 1985

Note: A blank indicates no response

Vet center	Year began operation	Location of center	Location of clients
Mobile, AL	1982	U	U/S
Moline, IL	1985	U	U/S
Monroeville, PA	1981	S	U/S
Montabello, CA	1979	S	U/S
Morgantown, WV	1982	R	R/S
N Charleston, SC	1980	U	U/S
N Chicago, IL	1986	U	•
New Bedford, MA	1986	U	U/S
New Haven, CT	1979	U	C
New Orleans, LA	1980	U	U/S
Newark, NY	1979	U	U/S
Norfolk, VA	1980	U	U/S
Northridge, CA	1979	U	•
Norwich, CT	1985	U	U/S
Oak Park, IL	•	S	U/S
Oakland, CA[a]	1981	U	U/S
Oakpark, MI	1980	U	U/S
Oklahoma City, OK	1980	U	U/S
Omaha, NE	1980	U	U/S
Orlando, FL	1983	U	U/S
Palm Beach CO, FL	1985	S	R/S
Pawtucket, RI[a]	1980	U	U/S
Pensacola, FL	1985	U	C
Peoria, IL	1981	R	C
Philadelphia, PA	1979	U	U/S

Vietnam era veteran population	Vietnam era veteran race/ethnic origin[d] (percent)			Male Vietnam era veterans (percent)	Distance to VA support facility (miles)	Vietnam era veterans needing PTSD treatment[e] (percent)	Distance to nearest designated PTSD unit (miles)
	White	Black	Other				
44,000	58	40	2	90	60	10	350
60,000	90	6	4	95	60	5	300
81,640	64	30	6	88	11	15	135
200,000	48	8	44	99	15	10	500
36,150	98	2	0	99	48	50	300
120,000	55	35	10	95	5	25	120
120,000	80	15	5	•	•	•	•
30,000	60	8	32	85	30	•	150
28,360	55	35	10	95	3	15	300
42,000	55	44	1	90	2	25	600
77,270	50	26	14	96	6	10	47
25,000	40	52	8	95	12	20	325
70,000	70	9	22	95	5	40	800
20,000	80	10	10	95	50	10	80
40,000	55	35	10	95	5	15	40
35,000	50	35	15	90	35	30	40
160,000	60	38	2	97	35	5	275
82,340	70	20	10	90	3	65	400
26,000	70	20	10	90	2	15	180
95,880	70	20	10	96	75	25	90
20,000	50	30	20	90	75	10	200
42,000	70	20	10	99	5	60	100
44,000	77	19	4	90	130	4	450
150,000	50	40	10	85	130	50	200
116,720	55	39	6	92	6	150	40

(continued)

[a] Vet center included in GAO review.

[b] U = urban, S = suburban, and R = rural.

[c] C = combined, U/S = urban/suburban, and R/S = rural/suburban.

[d] Totals may not equal 100 percent because we accepted questionnaire respondents' figures if they totaled 90-110 percent.

[e] Number of Vietnam era veterans identified as needing inpatient PTSD treatment in fiscal year 1985.

Note: A blank indicates no response.

Vet center	Year began operation	Location of center	Location of clients
Philadelphia, PA	1982	U	U/S
Phoenix, AZ	1980	U	U/S
Pittsburgh, PA	1980	U	U/S
Pleasantville, NJ	1986	S	U/S
Pocatello, ID	1985	R	R/S
Ponce, PR	1985	U	C
Portland, ME	1979	U	U/S
Portland, OR	1980	U	U/S
Prescott, AZ	1985	R	R/S
Provo, UT	1984	U	R/S
Queens, NY	1985	U	U/S
Rapid City, SD	1982	R	U/S
Reno, NV	1981	R	R/S
Richmond, VA	1982	U	U/S
Rio Piedras, PR	1980	U	U/S
Riverside, CA	1982	S	C
Roanoke, VA	1985	R	R/S
Rochester, NY	1986	U	U/S
Sacramento, CA	1985	U	U/S
Salem-Corvallis, OR	1986	S	•
Salt Lake City, UT	1980	U	U/S
San Antonio, TX	1980	U	C
San Antonio, TX	•	U	U/S
San Bernadino CO, CA	1986	S	
San Diego, CA	1980	U	U/S

Vietnam era veteran population	Vietnam era veteran race/ethnic origin[d] (percent)			Male Vietnam era veterans (percent)	Distance to VA support facility (miles)	Vietnam era veterans needing PTSD treatment[e] (percent)	Distance to nearest designated PTSD unit (miles)
	White	Black	Other				
71,500	50	40	10	80	12	•	38
105,000	45	10	45	95	3	30	3
121,307	78	20	2	98	10	2	120
70,000	85	12	3	99	75	•	•
35,000	72	1	27	95	164	11	770
7,000	2	0	98	99	80	27	1,045
20,660	93	1	6	80	65	45	260
55,000	92	3	5	98	6	12	120
11,000	80	1	19	97	3	12	95
20,000	97	1	2	90	55	•	•
37,500	50	30	20	99	20	10	50
7,000	85	1	14	99	30	10	1,000
30,000	84	4	12	95	2	50	250
91,000	•	•	•	•	5	60	20
25,000	0	0	100	97	1	140	1,045
65,000	40	10	50	90	30	10	600
25,000	62	37	1	96	5	10	300
44,000	50	25	25	90	40	2	400
120,000	80	12	8	93	80	•	•
70,660	•	•	•	•	50	•	•
70,000	90	2	9	99	6	20	700
50,000	44	7	49	98	12	15	900
53,000	50	3	47	•	6	2	800
65,000	40	10	50	90	30	•	•
106,000	60	12	28	95	12	75	800

(continued)

[a] Vet center included in GAO review.

[b] U = urban, S = suburban, and R = rural.

[c] C = combined, U/S = urban/suburban, and R/S = rural/suburban.

[d] Totals may not equal 100 percent because we accepted questionnaire respondents' figures if they totaled 90-110 percent.

[e] Number of Vietnam era veterans identified as needing inpatient PTSD treatment in fiscal year 1985.
Note: A blank indicates no response.

Vet center	Year began operation	Location of center	Location of clients
San Diego, CA	1985	U	U/S
San Francisco, CA	1980	U	U/S
San Jose, CA[a]	1980	S	U/S
Santa Barbara, CA	1985	S	R/S
Santa Cruz, CA	1985	S	R/S
Santa Fe, NM	1985	R	R/S
Sarasota, FL	1985	S	R/S
Savannah, GA	1986	U	R/S
Scranton, PA	1985	U	U/S
Seattle, WA	1979	U	U/S
Silver Spring, MD	1980	S	U/S
Sioux City, IA	1981	R	R/S
Sioux Falls, SD	1980	R	R/S
Spokane, WA	1981	U	U/S
Springfield, IL	1985	U	U/S
Springfield, MA[a]	1982	U	C
St Croix, PR	1985	R	R/S
St Louis, MO	1981	U	U/S
St Louis, MO	1985	S	U/S
St Paul, MN	1980	U	U/S
St Petersburg, FL[a]	1980	U	U/S
St Thomas, PR	1985	U	U/S
Syracuse, NY	1985	U	C
Tacoma, WA	1979	S	U/S
Tallahassee, FL	1985	U	U/S

Vietnam era veteran population	Vietnam era veteran race/ethnic origin[d] (percent)			Male Vietnam era veterans (percent)	Distance to VA support facility (miles)	Vietnam era veterans needing PTSD treatment[e] (percent)	Distance to nearest designated PTSD unit (miles)
	White	Black	Other				
106,000	60	10	30	95	25	10	500
80,350	45	20	36	90	5	36	25
60,000	50	12	38	95	25	25	25
45,000	75	5	20	95	120	•	•
35,000	30	20	50	90	100	10	100
8,000	20	0	80	98	65	10	900
28,530	85	10	5	96	35	3	35
28,000	60	35	5	95	132	5	130
159,090	95	3	2	98	15	10	80
110,000	65	15	20	90	4	25	50
42,000	50	50	0	99	7	10	170
30,000	74	5	21	90	90	15	650
20,690	90	0	10	95	3	10	400
60,000	90	2	8	90	4	10	300
25,000	60	39	1	99	100	5	200
50,000	74	15	11	90	30	25	30
30,000	1	54	45	98	60	10	1,450
100,000	64	30	6	96	18	100	300
•	60	33	7	98	25	25	300
140,000	90	6	4	99	8	32	170
63,000	75	20	5	96	9	75	9
3,000	20	70	10	95	150	•	•
20,500	65	20	15	94	2	15	100
40,000	73	10	17	99	12	20	12
50,000	80	20	0	98	115	•	•

(continued)

[a] Vet center included in GAO review.

[b] U = urban, S = suburban, and R = rural.

[c] C = combined, U/S = urban/suburban, and R/S = rural/suburban.

[d] Totals may not equal 100 percent because we accepted questionnaire respondents' figures if they totaled 90-110 percent.

[e] Number of Vietnam era veterans identified as needing inpatient PTSD treatment in fiscal year 1985.

Note: A blank indicates no response.

Vet center	Year began operation	Location of center	Location of clients
Tampa, FL	1981	U	U/S
Trenton, NJ	1982	U	U/S
Tulsa, OK	1981	U	U/S
Tuscon, AZ	1980	S	U/S
Washington, DC	1980	U	U/S
Wasilla, AK	1980	R	R/S
White Plains, NY	1983	S	U/S
White River JCT, VT	1981	R	R/S
Wichita, KS	1980	U	U/S
Williston, VT	1980	R	R/S
Wilmington, DE	1980	U	U/S
Worchester, MA	1985	S	C

Vietnam era veteran population	Vietnam era veteran race/ethnic origin[d] (percent)			Male Vietnam era veterans (percent)	Distance to VA support facility (miles)	Vietnam era veterans needing PTSD treatment[e] (percent)	Distance to nearest designated PTSD unit (miles)
	White	Black	Other				
39,000	50	35	15	80	7	15	35
54,280	45	50	5	90	50	50	50
48,300	49	10	41	96	60	7	300
30,000	50	5	45	95	18	8	130
44,000	30	65	5	95	5	20	200
20,000	97	1	2	99	60	3	3,000
50,000	60	30	10	95	15	20	13
35,000	99	1	0	95	1	4	100
12,600	55	30	15	90	4	15	125
13,000	96	1	3	95	90	3	150
57,200	65	30	4	98	4	50	30
24,505	85	4	11	96	65	30	50

[a] Vet center included in GAO review.

[b] U = urban, S = suburban, and R = rural.

[c] C = combined, U/S = urban/suburban, and R/S = rural/suburban.

[d] Totals may not equal 100 percent because we accepted questionnaire respondents' figures if they totaled 90-110 percent.

[e] Number of Vietnam era veterans identified as needing inpatient PTSD treatment in fiscal year 1985.

Note: A blank indicates no response.

GAO's Questionnaire Design and Methodology

In February 1986, we sent a questionnaire to all vet centers and satellite centers to obtain information concerning the administration and operation of the Readjustment Counseling Program. This appendix contains a technical description of our questionnaire design, pretest procedures, and response rate.

Questionnaire Design

The questionnaire was designed to elicit vet center team leaders' and satellite coordinators' knowledge of and experiences with the administration and operation of their vet centers. Specifically, we asked team leaders and coordinators from each vet center reviewed about

- their staffs' qualifications and training,
- services provided by their staffs and others at the vet center,
- characteristics of the veterans served by the center, and
- their relationship with referral agencies and other VA facilities.

Questionnaire Pretest and Response Rate

Before the questionnaire was used, we pretested it at five vet centers representing locations that served urban, suburban, and rural Vietnam era veterans. In addition, the Readjustment Counseling Service director reviewed it.

During the pretest, respondents completed the questionnaire while a trained GAO observer noted unobtrusively the time the respondents took to complete each question and any difficulties they experienced. We used a standardized procedure to elicit the respondents' description of the various difficulties encountered as they completed each item; the standard procedure involved only nondirect inquiries to ensure that we did not ask the respondents leading questions.

Based on the pretest results, we revised the questionnaire to ensure that (1) the intended respondents could and would provide the information requested and (2) all questions were fair, relevant, easy to answer, and relatively free of design flaws that could introduce bias or error into the study results. We also tested to ensure that completing the questionnaire would not place too great a burden on the respondents.

A total of 187[1] questionnaires were mailed, including 160 to vet centers and 27 to satellite centers. We received a 100- percent response rate.

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[1] A 188th vet center, in Springfield, Va., was not operating as of February 1986. Therefore, we did not ask its team leader to complete a questionnaire.

Determining the Accuracy of the Readjustment Counseling Program's Computerized Data Base

Description of Sampling Methodology

Our objective was to determine the extent of the discrepancy between information in the Readjustment Counseling Service computerized data base and information in data processing source documents or other information contained in client folders at the 12 vet centers we visited.

From the data base, we identified a universe of 3,999 clients for all 12 vet centers. This universe represents the 12 centers' total number of clients who had at least one visit within 180 days before July 31, 1985. This ensured that the clients selected would be relatively recent ones. From this universe, we selected a random sample of 100 clients.

For each of the clients in our sample, we selected eight personal and military service data elements to examine: sex of the veteran, date of birth, racial/ethnic status, marital status, education level, employment status, period of military service, and the extent of VA service-connected disability status. We also examined the data elements describing clients' problems.

Verification of Data Elements

To meet our objectives, we compared the data elements (in the computerized data base) with the information on the source document in the client's folder. If a discrepancy existed, we considered this to be a keypunch error. For personal data and military service data, we also compared the data elements in the computerized data base with any other available information in the client folder. If a discrepancy existed, we considered this to be a substantive error. If there were no documents in the file with which to verify the data base, we assumed the data base was correct. We did not examine the data concerning client problems for substantive errors because there was not sufficient documentation in the files for us to verify that information.

Estimating the Number of Errors

From our sample, we identified 522 elements of client problem data and found two keypunch errors, resulting in a keypunch error rate of 0.4 percent. From our sample, we also estimated the percentage of keypunch and substantive errors for each of the eight personal and military service data elements. Because we selected a random sample of clients from the 12 centers visited, each estimate of the percentage of keypunch and substantive errors for the eight data elements has a sampling (that is, measurement precision) error. This is the maximum amount by which the estimate obtained from a random sample can be expected to differ from the true universe characteristic (value) we are estimating. Sampling errors are usually stated at a certain confidence level—in this case, 95 percent. This means the chances are 19 out of 20 that if we reviewed the eight data elements for all active clients at the 12 vet centers, the results would differ from the estimates obtained from our sample by less than the sampling errors of the estimates.

A visual explanation of our sampling is given in table IV.1.

Table IV.1: Summary of Sample Used to Determine Keypunch and Substantive Errors

Data element	Universe	Sample	Percent of keypunch errors	Sampling error +/- (percent)	Percent of substantive errors	Sampling error +/- (percent)
	3,999	100				
Sex of veteran			4	3.8	1	1.9
Date of birth			3	3.3	7	5.0
Racial/ethnic			2	2.7	2	2.7
Marital status			4	3.8	3	3.3
Education level			1	1.9	14	6.8
Employment			2	2.7	3	3.3
Period of service			4	3.8	1	1.9
Extent of VA service-connected disability status			3	3.3	16	7.2

Comments From the Veterans Administration

Office of the Administrator of Veterans Affairs
Washington DC 20420

Veterans Administration

JUN 11 1987

Mr. Richard L. Fogel
Assistant Comptroller General
Human Resources Division
U.S. General Accounting Office
Washington, DC 20548

Dear Mr. Fogel:

This responds to your April 29, 1987, draft report VIETNAM VETERANS: A Profile of VA's Readjustment Counseling Program. The General Accounting Office (GAO) examined specific aspects of the program to review the (1) number, characteristics, and problems of the veteran clients; (2) services provided by the readjustment counseling centers (vet centers) and the qualifications and training of staff; (3) program management, oversight, and recordkeeping; (4) centers' coordination with post-traumatic stress disorder units; and (5) centers' relations with VA medical centers, community treatment programs, veterans, and the public.

We endorse the GAO recommendation that the House and Senate Committees on Veterans' Affairs consider permitting VA to decide on a case-by-case basis whether or not to retain the vet centers in "storefront" locations instead of relocating them to VA medical facilities over a 2-year period, beginning October 1, 1987, as required by current law. This will permit the Agency to consider each center's changing needs and the method and location best suited to meeting those needs.

The report contains recommendations to the VA on client followup, evaluating the quality of clinical and training support provided vet centers, and collaboration between vet centers and post-traumatic stress disorder units. Other recommendations concern regional officials' site visits to vet centers and inclusion of vet center operations in internal and external reviews. The VA either fully concurs in the recommendations, or concurs in principle. The enclosure contains detailed comments on each recommendation, as well as general comments on the report text.

Sincerely,

THOMAS K. TURNAGE
Administrator

Enclosure

ENCLOSURE

VETERANS ADMINISTRATION COMMENTS ON THE
APRIL 29, 1987, GAO DRAFT REPORT VIETNAM VETERANS:
A PROFILE OF VA'S READJUSTMENT COUNSELING PROGRAM

Chapter 6 Recommendation:

In view of their finding that the vet centers did not always conduct followup of their clients, GAO **recommended that the Administrator direct the Chief Medical Director to clarify the importance of client followup, and if followup is considered important, monitor regional officials' site visit reports to determine whether it has been adequately conducted.**

The VA concurs. We plan to distribute revised guidance concerning followup requirements by the end of the current fiscal year. By the same target date, regional management officials' site visit reports will reflect an assessment and evaluation of followup activities.

Chapter 7 Recommendations:

The GAO concluded that most vet centers and support facilities collaborated in some way on administrative, clinical, and training matters, but distance between the vet center and its support facility affected clinical and training collaboration. **GAO recommended that the Administrator direct the Chief Medical Director to determine whether any outpatient clinic located closer than the current support facility could better provide clinical and training support to the vet center.**

We concur, and by July 31, 1987, expect to forward guidance to the field, instructing vet centers and VA outpatient clinics located in proximity to participate in each other's clinical and training activities.

The report states that in addition to the law requiring, when appropriate, that post-traumatic stress disorder (PTSD) and vet center services be coordinated, the Special Committee on PTSD has indicated that close contact between vet centers and specialized PTSD inpatient units could improve treatment effectiveness. **It is recommended that the Administrator direct the Chief Medical Director to strengthen collaboration between vet centers and PTSD units by requiring them to establish formal communication regarding all clients referred from one facility to the other.**

We concur, and by July 31, instructions will be sent to the field, requiring collaboration according to basic standards of sound clinical practice. Increased information sharing between the PTSD units and the vet centers has already begun, including the participation of vet center staff in PTSD regional conferences.

Chapter 8 Recommendations:

The report states that regional officials' site visits to vet centers are useful in managing program operations, but circumstances may prevent visits from being made as frequently as is desirable. **GAO recommends that the Administrator direct the Chief Medical Director to emphasize the need for**

2.

regional officials to make their required site visits, monitor whether the officials are making the visits as required, and, where not enough visits are being made, request that the support facilities monitor the administrative and clinical activities at the centers.

We concur. During April 1987, all regional management officials were instructed to complete the required number of administrative and clinical site visits for the current fiscal year. A monthly report to Central Office from each region, documenting the number of visits accomplished in the fiscal year to date, was instituted. We anticipate these steps will assure that target standards are uniformly met in the future.

Chapter 9 Recommendation:

GAO states that although the Readjustment Counseling Service established mechanisms to assure quality care, it has little assurance that the centers are providing quality care because of inadequate clinical recordkeeping practices and file review procedures. **GAO recommends that the Administrator, through the Chief Medical Director, (1) require the Department of Medicine and Surgery regional offices to include the vet centers in their systematic external review programs (SERP); (2) require medical center directors to include vet centers in their systematic internal reviews (SIR); and (3) establish specific requirements for regional and team leader reviews of clinical files, including specifying the minimum frequency, magnitude, and documentation requirements, and requiring the reviewers to comment on quality of care provided to clients.**

We concur in the first part of the recommendation, concerning SERP, and have begun implementation. By the end of the fiscal year, an ad hoc task force will provide recommendations for accomplishing SERP reviews of vet centers. In addition, a SCEM (Standards, Criteria, and Evaluative Methodology--the major document used as criteria in conducting SERP surveys) for use in vet center surveys, has been drafted and should be ready for publication by the end of September 1987.

We agree, in principle, with the second part of the recommendation--that medical centers should review the support they provide to vet centers. However, it would be inappropriate to require medical center directors to include vet centers in their SIR activity because they do not direct vet center operations. Systematic internal reviews by vet center team leaders and readjustment counseling regional management staff will automatically follow from implementing the new vet center SCEM for external reviews. Beginning in fiscal year 1988, the vet center liaison officer at each medical center will routinely receive the results of vet center SIR's, and medical facility directors may, as a local option, include vet centers in selected parts of their internal review program.

We concur that there should be specific requirements for clinical file reviews. The SCEM for vet center operations will describe systematic internal review requirements, and the site visit report format will be revised to indicate minimum frequency and documentation requirements.

3.

General Comments on the Report Text

Now on p. 33.

Chapter 4, page 37 and following, concerning accuracy of the program data base:

The data system used from 1980 through 1984 was cumbersome, and the system promulgated in 1985 was even more so. Both systems were based on the generation of a separate form for every encounter between a staff member and a client, leading to the need to mail and keypunch tens of thousands of forms each month. Because of bulk, the system was difficult to audit and paperwork burdens on staff were inappropriate. Most problems described by GAO derive from these fundamental defects, and were compounded by the fact that both systems attempted to obtain data in three discrete areas: demographic information, clinical information, and workload.

At the beginning of fiscal year 1987, a much more streamlined system was instituted. It concentrates on workload data, with a minimum amount of clinical information contained in a 10-item problem list. This system requires staff to maintain a daily log but eliminates the separate forms for every contact. The staff time thus freed can be devoted to recording clinical and demographic data in the individual counseling records.

Now on p. 41.

Chapter 5, page 57 and following, concerning training:

We believe that when recently hired team leaders and satellite coordinators responded to the GAO questionnaire, they underreported the training they received. There were no instructions for staff to refer to their training conference agendas when completing the questionnaire, and it is likely that a certain proportion did not accurately report their orientation training. Nonetheless, GAO's findings concerning training are cause for concern, and regional management staff have been instructed to assure that newly hired staff uniformly obtain training in the key areas specified in Table 5.2 of the report.

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